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Canada Health Act

Annual Report
2001-2002

Canada

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Rapport annuel de 2001-2002 sur l'application de la Loi canadienne sur la santé

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Minister of Health Ministre de la Santé

The Honourable/L'honorable A. Anne McLellan

Ottawa, Canada K1A 0K9

December, 2002

Her Excellency, the Right Honourable Adrienne Clarkson,
Governor General and Commander-in-Chief of Canada

May it please Your Excellency:

The undersigned has the honour to present to Your Excellency the Annual Report on the administration and operation of the *Canada Health Act* for the fiscal year ended March 31, 2002.

A Anne McLell

A. Anne McLellan

Canada

Preface

As was stated by Her Excellency, the Governor General of Canada, in the Speech from the Throne on September 30, 2002, "no issue touches Canadians more deeply than health care. Our health care system is a practical expression of the values that define us as a country." These values are fairness, equity and solidarity.

This has been a remarkable and historic year for the renewal and long-term sustainability of our health care system. On November 28, 2002, I tabled in the House of Commons the final report of the Commission on the Future of Health Care in Canada, *Building on Values—The Future of Health Care in Canada*. The Government of Canada welcomes this report prepared by Commissioner Roy J. Romanow, Q.C., and thanks him for his hard work and commitment on behalf of Canadians. His report is an essential contribution to the discussion of how we sustain our publicly funded health care system for the long term. Canadians also have the benefit of other federal, provincial and territorial reviews of our health care system in the recent past. Together, these reports provide a strong foundation from which to move forward.

Following the release of Commissioner Romanow's report, I met with my provincial and territorial counterparts to initiate discussions in preparation for the first ministers' meeting to be convened by the Prime Minister in early 2003. The Prime Minister will convene this meeting of first ministers to establish a comprehensive plan for reform to modernize medicare, including enhanced accountability to Canadians. This plan will include the necessary federal long-term investments, which will be included in the next budget.

During this time of discussion and debate, the Government of Canada has continued to uphold the principles of the *Canada Health Act* with respect to the provision of insured medically necessary hospital and physician services. Since the Auditor General's report in 1999, at which time it was noted that "Health Canada does not have the information it needs to effectively monitor and report on the extent of compliance with the *Canada Health Act*," improvements have been made to the administration of the Act including better reporting to Parliament and Canadians in the form of an enhanced annual report and the addition of new resources and staff at headquarters and in the regions. In April 2002, I reached an agreement with the provinces and territories with respect to a dispute avoidance and resolution process to help resolve *Canada Health Act* interpretation issues. This was a key recommendation of the 1999 audit. A follow-up audit in 2002 suggested that further progress can be made and, in this regard, Health Canada will continue to address gaps in information collection in order to fulfill its obligation to administer the Act.

Our goal in administering the *Canada Health Act* is to maintain provincial and territorial compliance with the principles of the Act in a cooperative, fair and open manner. When issues related to possible non-compliance are identified, they are usually resolved at the officials' level efficiently and without the imposition of penalties. Of the *Canada Health Act* compliance issues under investigation, two were resolved in 2001-2002. One issue related to queue jumping in Ontario for medically necessary Magnetic Resonance Imaging services at a hospital; the other to charges for medically necessary Computed Tomography services in British Columbia.

Canadians want their governments to work together to manage health system issues better and with greater transparency and openess. Together with my provincial and territorial colleagues, my priority must and will be to do so, and to ensure that we have an accessible, quality health care system that remains true to the values of Canadians and the principles of the Act and is sustainable over the long term.

A Anne McLell

A. Anne McLellan
Minister of Health

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Health Canada would like to acknowledge the work and effort that went into producing this Annual Report. It is through the dedication and timely commitment of the following departments of health and their staff that we are able to bring you this report on the administration and operation of the *Canada Health Act*.

Newfoundland and Labrador Department of Health and Community Services

Prince Edward Island Health and Social Services

Nova Scotia Department of Health

New Brunswick Department of Health and Wellness

Ministère de la Santé et des Services sociaux du Québec

Ontario Ministry of Health and Long-Term Care

Manitoba Health

Saskatchewan Health

Alberta Health and Wellness

British Columbia Ministry of Health Services
British Columbia Ministry of Health Planning

Yukon Department of Health and Social Services

Northwest Territories Department of Health and Social Services

Nunavut Department of Health and Social Services

We also greatly appreciate the extensive work effort that was put into this report by our production team: the desktop publishing unit, the translators, editors and concordance experts, and staff of Health Canada at headquarters and in the regional offices.

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Introduction

The five principles of the *Canada Health Act* are the cornerstone of the Canadian health care system, and reflect the values that inspired Canada's single-payer, publicly-financed health care system, over 40 years ago. This legislation, passed unanimously by Parliament in 1984, affirms the federal government's commitment to a universal, accessible, comprehensive, portable and publicly administered health insurance system. The Act aims to ensure that all residents of Canada have access to necessary hospital and physician services on a prepaid basis. The *Canada Health Act* defines for the provinces and territories the criteria and conditions that they must satisfy in order to qualify for their full share of federal transfers under the Canada Health and Social Transfer (CHST).

This report is produced in accordance with the requirement set out in section 23 of the *Canada Health Act*:

> "The Minister shall, as soon as possible after the termination of each fiscal year and in any event not later than December 31 of the next fiscal year, make a report respecting the administration and operation of this Act for that fiscal year, including all relevant information on the extent to which provincial health care insurance plans have satisfied the criteria, and the extent to which the provinces have satisfied the conditions, for payment under this Act and shall cause the report to be laid before each House of Parliament on any of the first fifteen days on which that House is sitting after the report is completed."

Under the *Canada Health Act*, the federal Minister of Health is required to provide information on the operation of provincial and territorial health care plans as they relate to the criteria and conditions of the Act. The approach to this information gathering has been collaborative, where provinces, territories and the federal government have worked together to supply the information needed by the Minister.

Chapter 1 provides an overview of the *Canada Health Act* and the associated regulations and policies that are used in the administration of the Act. Chapter 2 reviews the administration of the *Canada Health Act* during 2001-2002, and includes a summary of compliance issues addressed, deductions levied, and noteworthy events which followed March 31, 2002. Chapter 3 presents descriptions of the provincial and territorial health insurance plans related to programs and services for the year ending March 31, 2002. Seven annexes, listed below, are also appended to this report, providing an array of additional information relevant to the administration of the Act and its place in the Canadian health care system.

Statistical data for each province and territory on insured hospital, physician and surgical dental health care services that come under the Act are detailed in Annex A. A copy of the *Canada Health Act* and its regulations (unofficial consolidation to June 2001) is available in Annex B. Annex C provides copies of the two key policy statements that clarify the federal interpretation of the criteria and conditions of the *Canada Health Act*. Annex D provides a description of the new Canada Health Act Dispute Avoidance and Resolution process which came into effect in 2002. Annex E summarizes the deductions and refunds from federal transfers under the provisions of the Act. Annex F describes the evolution of federal transfers for health care in Canada. Annex G provides a glossary of terminology used in this report. Inside the back cover you will find contact information for provincial and territorial departments of health.

Chapter 1 – Canada Health Act Overview

> *"The principles of the Canada Health Act began as simple conditions attached to federal funding for medicare. Over time, they became much more than that. Today, they represent both the values underlying the health care system and the conditions that governments attach to funding a national system of public health care. The principles have stood the test of time and continue to reflect the values of Canadians."*
>
> *(Roy J. Romanow, Q.C. November, 2002)*

In this chapter we describe the *Canada Health Act*, its provisions and principles, and the exclusions under the Act. Also described are the regulations and regulatory provisions of the *Canada Health Act* and the two official letters used for policy interpretation of the Act. These interpretation letters by former federal Ministers of Health Jake Epp and Diane Marleau to their provincial and territorial counterparts are used in the interpretation and application of the Act.

What is the Canada Health Act?

The *Canada Health Act* is Canada's federal health insurance legislation.

The Act sets out the primary objective of Canadian health care policy: "to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers."

The *Canada Health Act* establishes criteria and conditions related to insured health care services and extended health care services that the provinces and territories must meet in order to receive the full federal cash contribution under the Canada Health and Social Transfer (CHST).

The aim of the *Canada Health Act* is to ensure that all eligible residents of Canada have reasonable access to medically necessary insured services on a prepaid basis, without direct charges at the point of service for such services.

Key Definitions under the CHA

There are two types of services defined in the *Canada Health Act*.

Insured health care services are medically necessary hospital, physician and surgical-dental services provided to insured persons.

Insured hospital services are defined under the *Canada Health Act* and include medically necessary in- and out-patient services such as standard or public ward accommodation; nursing services; diagnostic procedures such as blood tests and x-rays; drugs administered in hospital; and the use of operating rooms, case rooms and anaesthetic facilities.

Insured physician services are defined under the Act as "medically required services rendered by medical practitioners." Medically required physician services are generally determined by physicians in conjunction with their provincial and territorial health insurance plans.

Insured surgical-dental services are services provided by a dentist in a hospital, where a hospital setting is required to properly perform the procedure.

Extended health care services as defined in the *Canada Health Act* are certain aspects of long-term residential care (nursing home intermediate care and adult residential care services), and the health aspects of home care and ambulatory care services.

Insured persons are eligible residents of a province or territory. A resident is defined in the *Canada Health Act* in relation to a province as "a person lawfully entitled to be or to remain in Canada who makes his home and is ordinarily present in the province, but does not include a tourist, a transient or a visitor to the province."

Persons excluded under the *Canada Health Act* include serving members of the Canadian Forces or Royal Canadian Mounted Police and inmates of federal penitentiaries.

Requirements of the Canada Health Act

The *Canada Health Act* contains the following nine requirements that the provinces and territories must meet in order to qualify for the full federal cash contributions:

- ☐ five program criteria that apply only to insured health care services;
- ☐ two conditions that apply to insured health care services and extended health care services; and
- ☐ extra-billing and user charge provisions that apply only to insured health care services.

The Criteria

1. Public Administration (section 8 of CHA)

The public administration criterion, set out in section 8 of the *Canada Health Act*, applies to provincial and territorial health care insurance plans. The intent of the public administration criterion is that the provincial and territorial health care insurance plans be administered and operated on a non-profit basis by a public authority, accountable to the provincial or territorial government for decision making on benefit levels and services, and whose records and accounts are publicly audited.

2. Comprehensiveness (section 9)

The comprehensiveness criterion of the *Canada Health Act* requires that, in order to be eligible for federal cash transfer payments, the health care insurance plan of a province or territory "must insure all insured health services provided by hospital, medical practitioners or dentists (i.e. surgical-dental services which require a hospital setting) and, where the law of the province so permits, similar or additional services rendered by other health care practitioners."

3. Universality (section 10)

Under the universality criterion, all insured residents of a province or territory must be entitled to the insured health services provided by the provincial or territorial health care insurance plan on uniform terms and conditions. Provinces and territories generally require that residents register with the plans to establish entitlement.

Newcomers to Canada, such as landed immigrants or Canadians returning from other countries to live in Canada, may be subject to a waiting period by a province or territory, not to exceed three months, before they are entitled to receive insured health care services.

4. Portability (section 11)

Residents moving from one province or territory to another must continue to be covered for insured health care services by the "home" jurisdiction during any waiting period imposed by the new province or territory of residence. The waiting period for eligibility to a provincial or territorial health care insurance plan must not exceed three months. After the waiting period, the new province or territory of residence assumes responsibility for health care coverage.

Residents who are temporarily absent from their home province or territory or from Canada, must continue to be covered for insured health care services during their absence. This allows individuals to travel or be absent from their home province or territory, within a prescribed duration, while retaining their health insurance coverage.

The portability criterion does not entitle a person to seek services in another province, territory or country, but is intended to permit one to receive necessary services in relation to an urgent or emergent need when absent on a temporary basis, such as on business or vacation.

If insured persons are temporarily absent in another province or territory, the portability criterion requires that insured services be paid at the host province's rate. If insured persons are temporarily out of the country, insured services are to be paid at the home province's rate.

Prior approval by the health care insurance plan in a person's home province or territory may also be required before coverage is extended for elective (non-emergency) services to a resident while temporarily absent from their province or territory.

5. *Accessibility (section 12)*

The intent of the accessibility criterion is to ensure that residents of a province or territory have reasonable access to insured hospital, medical and surgical-dental services on uniform terms and conditions, unprecluded or unimpeded, either directly or indirectly, by charges (user charges or extra-billing) or other means (e.g., discrimination on the basis of age, health status or financial circumstances). In addition, the health care insurance plans of the province or territory must provide:

- ☐ reasonable compensation to physicians and dentists for all the insured health care services they provide; and
- ☐ payment to hospitals to cover the cost of insured health care services.

Reasonable access in terms of physical availability of medically necessary services has been interpreted under the *Canada Health Act* using the "where and as available" rule. Thus, residents of a province or territory are entitled to have access on uniform terms and conditions to insured health care services at the setting "where" the services are provided and "as" the services are available in that setting.

The Conditions

Information (section 13(a)) — the provincial and territorial governments are to provide information to the Minister of Health as may be reasonably required, in relation to insured health care services and extended health care services, for the purposes of the *Canada Health Act*.

Recognition (section 13(b)) — the provincial and territorial governments are to recognize appropriately the federal financial contributions toward both insured and extended health care services.

Extra-billing and User Charges

The provisions of the *Canada Health Act* which discourage extra-billing and user charges for insured health services in a province or territory are outlined in sections 18 to 21. If it can be determined that either extra-billing or user charges exist in a province or territory, a mandatory deduction from the federal cash transfer to that province or territory is required under the Act. The amount of such a deduction for a fiscal year is determined by the federal Minister of Health based on information provided by the province or territory in accordance with the *Extra-billing and User Charges Information Regulations* described below.

Extra-billing (section 18)

Under the *Canada Health Act*, extra-billing is defined as the billing for an insured health service rendered to an insured person by a medical practitioner or a dentist (i.e. a surgical-dentist providing insured health services in a hospital setting) in an amount in addition to any amount paid or to be paid for that service by the health care insurance plan of a province or territory. For example, if a physician were to charge patients five dollars for an office visit that is insured by the provincial or territorial health insurance plan, the five-dollar charge would constitute extra-billing. Extra-billing is seen as a barrier or impediment for people seeking medical care, and is therefore contrary to the accessibility criterion.

User Charges (section 19)

The *Canada Health Act* defines user charges as any charge for an insured health service other than extra-billing that is permitted by a provincial or territorial health care insurance plan and is not payable by the plan. For example, if patients were charged a facility fee for receiving an insured service at a hospital or clinic, the fee would be considered a user charge. User charges are not permitted under the Act as, like extra-billing, they constitute a barrier to access.

Other Elements of the Act

Regulations (section 22)

Section 22 of the *Canada Health Act* enables the federal government to make regulations for the administration of the Act in the following areas:

- ☐ prescribing which services to include in the CHA definition of "extended health care services;"
- ☐ prescribing which services to exclude from hospital services;
- ☐ prescribing the types of information that the federal Minister of Health may reasonably require from a province or territory to qualify for a full federal transfer;
- ☐ prescribing how provinces and territories are required to give recognition to the Canada Health and Social Transfer in their documents, advertising or promotional materials.

The only regulations in force under the Act are the *Extra-billing and User Charges Information Regulations*, which require the provinces and territories to provide estimates of extra-billing and user charges prior to the beginning of a fiscal year so that appropriate penalties can be levied, as well as financial statements showing the amounts actually charged so that reconciliations with the actual deductions can be made. (A copy of these regulations is provided in Annex B).

Penalty Provisions of the Canada Health Act

Mandatory Penalty Provisions

Under the *Canada Health Act*, provinces and territories that allow extra-billing and user charges are subject to mandatory dollar-for-dollar deductions from the federal transfer payments under the CHST. For example, if it has been determined that a province has allowed $500,000 in extra-billing by physicians, the federal transfer payments to that province would be reduced by that amount.

Discretionary Penalty Provisions

Breaches of the five criteria and two conditions of the *Canada Health Act* are subject to discretionary penalties. The amount of any deduction from federal transfer payments under the CHST is based on the gravity of the default.

The *Canada Health Act* sets out a consultation process that must be undertaken with the province or territory before discretionary penalties can be levied. To date, the discretionary penalty provisions of the Act have not been applied.

Health Care Services Outside the Act

Although the *Canada Health Act* requires that insured health services be provided to insured persons in a manner that is consistent with the criteria and conditions set in the Act, not all Canadian residents or health services fall under the scope of the Act. There are two categories of exclusion for insured services:

- ☐ services which fall outside the definition of insured health care services (definition on page 3); and
- ☐ certain services and groups of persons are excluded from the definitions for insured services and insured persons.

These exclusions are discussed below.

Non-Insured Health Care Services

In addition to the medically necessary insured hospital and physician services covered by the *Canada Health Act*, provinces and territories also provide a range of programs and services outside the scope of the Act. These are provided at provincial and territorial discretion, on their own terms and conditions, and vary from one province or territory to another. Additional services that may be provided include home care, pharmacare, ambulance services, optometric services and dental services.

The additional services provided by provinces and territories may be targeted to specific population groups (e.g., children or seniors, or social assistance recipients), and may be partially or fully covered by provincial and territorial health insurance plans.

A number of services provided by hospitals and physicians are not considered medically necessary, and thus are not insured under provincial and territorial health insurance legislation. Uninsured hospital services for which patients may be charged include preferred hospital accommodation unless prescribed by a physician, private duty nursing services, and the provision of telephones and televisions. Uninsured physician services for which patients may be charged include telephone advice, the provision of medical certificates required for work, school, insurance purposes and fitness clubs, testimony in court, and cosmetic services.

Non-Insured Persons

The *Canada Health Act* definition of "insured person" excludes members of the Canadian Forces, persons appointed to a position of rank within the Royal Canadian Mounted Police, persons serving a term of imprisonment within a federal penitentiary, and persons who have not completed a minimum period of residence in a province or territory (a period that must not exceed three months). In addition, the definition of "insured health services" excludes services to persons provided under any other Act of Parliament (e.g., foreign refugees) or under the workers' compensation legislation of a province or territory.

The exclusion of these persons from insured health service coverage predates the adoption of the *Canada Health Act* and is not intended to constitute differences in access to publicly insured health care.

Policy Interpretation Letters

There are two key policy statements that clarify the federal position on the *Canada Health Act*. These statements have been made in the form of ministerial letters from former Federal Health Ministers to their provincial and territorial counterparts. Both letters are reproduced in Annex C of this report.

Epp Letter

In June 1985, approximately one year following the passage of the *Canada Health Act* in Parliament, then-federal Health Minister Jake Epp wrote to his provincial and territorial counterparts to set out and confirm the federal position on the interpretation and implementation of the *Canada Health Act*.

Minister Epp's letter followed several months of consultation with his provincial and territorial counterparts. The letter sets forth statements of federal policy intent which clarify the criteria, conditions and regulatory provisions of the CHA. These clarifications have been used by the federal government in the assessment and interpretation of compliance with the Act. The Epp letter remains an important reference for interpretation of the Act.

Federal Policy on Private Clinics

Between February 1994 and December 1994, a series of seven federal/provincial/territorial meetings dealing wholly or in part with private clinics took place. At issue was the growth of private clinics providing medically necessary services funded partially by the public system and partially by patients and its impact on Canada's universal, publicly funded health care system.

At the Federal/Provincial/Territorial Health Ministers Meeting of September 1994 in Halifax all ministers of health present, with the exception of Alberta's health minister, agreed to "take whatever steps are required to regulate the development of private clinics in Canada."

Diane Marleau, the federal Minister of Health at the time, wrote to all provincial and territorial ministers of health on January 6, 1995 to announce the new Federal Policy on Private Clinics. The Minister's letter provided the federal interpretation of the *Canada Health Act* as it relates to the issue of facility fees charged directly to patients receiving medically necessary services at private clinics. The letter stated that the definition of "hospital" contained in the *Canada Health Act*, includes any public facility that provides acute, rehabilitative or chronic care. Thus, when a provincial/territorial health insurance plan pays the physician fee for a medically necessary service delivered at a private clinic, it must also pay the facility fee or face a deduction from federal transfer payments.

Chapter 2 - Administration and Compliance

Administration

The *Canada Health Act* empowers the Minister of Health to investigate and administer the compliance of provinces and territories with the nine requirements of the Act described in the previous chapter. In exercising this responsibility, the Minister is assisted by Health Canada policy, communications and information officers located in Ottawa and in regional offices of the department, and by lawyers with the Department of Justice.

The Canada Health Act Division

The Canada Health Act Division is part of the Intergovernmental Affairs Directorate of the Health Policy and Communications Branch at Health Canada and is responsible for administering the *Canada Health Act*. Officers of the Division located in Ottawa and in regional Health Canada offices fulfill the following ongoing functions:

- monitoring and analysing provincial and territorial health insurance plans for compliance with the criteria, conditions and extra-billing and user charge provisions of the *Canada Health Act* (CHA);
- working in partnership with provinces and territories to investigate and resolve CHA compliance issues and pursue activities that encourage compliance with the Act;
- informing the Minister of possible non-compliance and recommending appropriate action to resolve non-compliance;
- developing and producing the Canada Health Act Annual Report on the administration and operation of the Act;
- developing and maintaining formal and informal contacts and partnerships with health officials in provincial and territorial governments to promote information sharing;
- collecting, summarizing and analysing relevant information on provincial and territorial health care systems;
- disseminating information on the *Canada Health Act* and on publicly-funded health care insurance programs in Canada;
- responding to information requests and correspondence relating to the *Canada Health Act*; and
- conducting issue analysis and policy research in order to provide policy options and recommendations to the Minister concerning the principles of the Act.

During 2001-2002, the Division reviewed several new issues of provincial and territorial compliance with the *Canada Health Act*. These issues of concern are described in the next section. In addition, the Division was involved in the following:

- collaboration with provincial and territorial health departments on the Federal/Provincial/Territorial Coordinating Committee on Reciprocal Billing (see below);
- development of a Dispute Avoidance and Resolution process for addressing issues related to the interpretation of the CHA principles;
- collaboration with provincial and territorial health departments on the supply, demand and delivery of magnetic resonance imaging (MRI) and computed tomography (CT) services in Canada;
- support to federal reviews of the Canadian health system concerning the *Canada Health Act* (Commission on the Future of Health Care in Canada; Senate Standing Committee on Social Affairs, Science and Technology; Auditor General of Canada Status Report on Federal Support for Health Care Delivery);
- production of a revised electronic edition of the Additional Benefits Information System, developed in collaboration with provincial and territorial officials as a source of information on publicly-funded health care services that are outside the scope of the *Canada Health Act*; and

- ☐ responses to over 2000 enquiries concerning a wide range of national, provincial and territorial health insurance issues received by telephone, mail, and e-mail from the public, Members of Parliament, government departments, stakeholder organizations and the media.

Coordinating Committee on Reciprocal Billing

The Canada Health Act Division chairs the Federal/Provincial/Territorial Coordinating Committee on Reciprocal Billing (CCRB) and acts as a Secretariat for the Committee. The Committee was formed in 1991 to deal with issues affecting the interprovincial billing of hospital and medical services as well as issues related to registration and eligibility for health insurance coverage.

The interprovincial/territorial portability provisions of the *Canada Health Act* are implemented through a series of bilateral reciprocal billing agreements between provinces and territories for hospital and physician services. This means that generally a patient's health card will be accepted, in lieu of payment, when the patient receives hospital or physician services in another province or territory. The province or territory providing the service will then directly bill the home province. All provinces and territories participate in reciprocal hospital agreements and all, with the exception of Quebec, participate in reciprocal medical agreements. The intent of these agreements is to ensure that Canadian residents do not face point-of-service charges for medically required hospital and physician services when they travel in Canada. However, these agreements are interprovincial/territorial and signing them is not a requirement of the Act.

In the fall of 2001, the CCRB mandated a working group to consult with the Canadian Institute for Health Information to update in-patient hospital billing rates for reciprocal billing purposes using the latest financial and statistical data available. These are the rates provinces and territories use to process claims for hospital services provided to out-of-province/territory residents. The new rates were implemented in the summer of 2002 to better reflect actual costs of hospital services received across the country.

Compliance

Health Canada's approach to resolving possible non-compliance issues emphasizes transparency, consultation and dialogue. In most instances, issues are resolved through consultation and discussion based on a thorough examination of the facts. Penalties are only applied when all options to resolve the issue have been exhausted.

Health Canada routinely monitors the operations of provincial and territorial health care insurance plans in order to provide advice to the Minister on possible non-compliance with the *Canada Health Act*. Examples of sources of this information are: media reports, provincial and territorial government publications, and correspondence from the public and other groups and individuals. To date, almost all disputes and issues related to the administration and operation of the *Canada Health Act* have been addressed and resolved without resorting to penalties.

Issues or enquiries that result from monitoring activities are assessed by departmental officials on a case-by-case basis. Many enquiries are not directly related to the *Canada Health Act* and are resolved quickly through verification of facts with provincial and territorial health officials. If there is a legitimate *Canada Health Act* issue identified, departmental officials will take the concern to the province and ask them to investigate. For example, an individual may raise concerns with Health Canada about being billed for a service that is not an insured service under the Act. Such issues are generally resolved through a fact-finding exercise and through discussions between officials of the respective levels of government. If there continue to be concerns related to a particular issue, Health Canada pursues the issue in question and, if necessary, the Minister of Health will raise the issue with her provincial counterpart to ensure the concerns are addressed and resolved.

The following describes CHA compliance issues dealt with in 2001-2002.

CHA Issues Arising in 2001-2002

For these issues, further information and analysis is required by Health Canada before a determination of compliance or non-compliance with the *Canada Health Act* can be made.

- ❑ ***Drugs administered in hospital*** — Remicade is an intravenous drug which is administered in hospital for the treatment of Crohn's Disease and Rheumatoid Arthritis. Saskatchewan was the first province to announce (November, 2001) that it would cover Remicade under its drug plan, with co-payments and deductibles. The CHA stipulates that medically necessary hospital services include drugs, biologicals and related preparations when administered in a hospital, and makes no distinction between out-patients and in-patients. Since then, some other provinces have adopted the same approach in covering these services.
- ❑ ***Non-medically necessary diagnostic services being sold in British Columbia*** — In November, 2001, it was reported that a hospital in Vancouver, British Columbia was selling non-medically necessary full-body computed tomography (CT) scans. The provincial Health Ministry responded that hospitals can charge individuals for non-medically necessary CT scans. Health Canada has requested a rationale from British Columbia for offering these services on a non-medically necessary basis.
- ❑ ***Out-of-province patients purchasing medically necessary hospital services in other provinces*** — Health Canada officials are reviewing the practice of private surgical and diagnostic clinics providing medically necessary insured services to residents of other Canadian provinces on a privately paid basis. Under the *Canada Health Act*, all residents of Canada must have reasonable access to medically necessary insured services on the basis of need, not ability to pay.

Compliance Issues Resolved in 2001-2002

- ❑ In December,1999, Health Canada became aware that insured residents in Ontario were privately purchasing magnetic resonance imaging services at an Ontario hospital under the guise of third-party payors and thereby jumping the queue for these services. Following bilateral discussions, Ontario provided information to Health Canada that confirms that the issue has been resolved.
- ❑ In November, 2001, the media reported that a British Columbia hospital was charging patients for medically necessary computed tomography (CT) scans. In March 2002, the British Columbia Ministry of Health Planning indicated that this practice had stopped and that all patient charges had been reimbursed.

Health Canada is continuing to clarify and resolve other previously reported issues with provinces to ensure there is compliance with the *Canada Health Act*.

Deductions

The Nova Scotia Department of Health does not cover the facility fee at the only private abortion clinic in the province. It does, however, pay the physician fee for abortions services provided by the clinic. This places the province in a position of non-compliance with the federal policy on private clinics. The federal policy on private clinics requires that provincial health insurance plans pay the physician fee for all medically necessary services delivered at a private clinic, and also pay the facility fee, or face deductions from federal transfer payments. Accordingly, between April 2001 and March 2002, monthly deductions of $3,250 were made from the Nova Scotia federal transfer payments under the Canada Health and Social Transfer (CHST). The amount of the deduction was based on estimates of user charges at the clinic, as submitted by the province. Total deductions made during fiscal year 2001-2002 amounted to $39,000.

Please refer to Annex E for a detailed chart of all penalties levied under the *Canada Health Act*; Annex F for further information on the Canada Health and Social Transfer; and Annex C for details on the federal policy on private clinics (Marleau letter).

Noteworthy Events in 2002-2003

In this section we report on several activities and announcements which relate to further developments on the *Canada Health Act* during fiscal year 2002-2003.

Report of the Auditor General of Canada

In October 2002, the Auditor General of Canada tabled in the House of Commons her first Status Report on the follow-up of federal departments to previous audit recommendations. Chapter 3 of the Status Report reflects the Auditor General's follow-up findings to the November 1999 audit on federal support of health care delivery. Although the Auditor General has acknowledged in her report that Health Canada has made some progress in addressing the weaknesses identified in the 1999 audit, she considers that the pace of the progress is not satisfactory. For its part, Health Canada has reiterated its commitment to improve information collection and monitoring activities in order to fulfil its obligations to administer the *Canada Health Act*.

Dispute Avoidance and Resolution

During 2001-2002, a federal/provincial/territorial working group of officials worked on developing a Dispute Avoidance and Resolution process for the interpretation of the principles of the *Canada Health Act*.

In April 2002, the Honourable A. Anne McLellan outlined in a letter to her provincial and territorial counterparts a Canada Health Act Dispute Avoidance and Resolution process, which was agreed to by provinces and territories, except Quebec (please see Annex D for a copy of the Minister's letter). The process meets federal and provincial/territorial interests of avoiding disputes related to the interpretation of the principles of the *Canada Health Act*, and when this is not possible, resolving disputes in a fair, transparent and timely manner.

The process includes the dispute avoidance activities of government-to-government information exchange, discussion and clarification, the continuing active participation of governments in *ad hoc* federal/provincial/territorial committees on *Canada Health Act* issues, and advance assessments upon request. Where dispute avoidance activities prove unsuccessful, dispute resolution activities may be initiated, beginning with government-to-government fact-finding and negotiations. If these are unsuccessful, either Minister of Health involved may refer the issues to a third party panel to undertake fact-finding and provide advice and recommendations.

The Minister of Health for Canada has the final authority to interpret and enforce the *Canada Health Act*. In deciding whether to invoke the non-compliance provisions of the Act, the Minister of Health for Canada will take the panel's report into consideration.

Commission on the Future of Health Care in Canada

In November 2002, the Final Report of the Commission on the Future of Health Care — *Building on Values: The Future of Health Care in Canada* — was tabled in the House of Commons. The Commission was established by the Prime Minister in April 2001, with the appointment of Commissioner Roy J. Romanow Q.C.. The mandate of the Commission was to engage Canadians in a national dialogue on the future of health care and to make recommendations to preserve the long-term sustainability of Canada's universally accessible, publicly funded health care system.

Commissioner Romanow's review, assessment and recommendations for Canada's health system were extensive. One of the areas of concern for the CHA is the provision of diagnostic services by private operators outside of the health system. Commissioner Romanow addresses this issue as follows:

> *"The rapid growth of private MRI (magnetic resonance imaging) clinics, which permit people to purchase faster service and then use test results to 'jump the queue' back into the public system for treatment, is a troubling case-in-point. So too is the current practice of some worker's compensation agencies of contracting with private providers to deliver fast-track diagnostic services to potential claimants. I agree with those who view these situations as incompatible with the 'equality of access' principle at the heart of medicare. Governments must invest sufficiently in the public system to make timely access to diagnostic services for all a reality and reduce the temptation to 'game' the system."*

Chapter 3 – Provincial and Territorial Health Care Insurance Plans in 2001-2002

The following chapter presents the 13 provincial and territorial health insurance plans that make up the Canadian health insurance system. The purpose of this chapter is to demonstrate clearly and consistently the extent to which provincial and territorial plans fulfilled the requirements of the *Canada Health Act* program criteria and conditions in 2001-2002.

Provincial and territorial officials were asked to provide narrative descriptions of their health insurance plans according to the program criteria areas of the *Canada Health Act* in order to illustrate how they satisfy these criteria. This narrative description also includes information on how their government met the *Canada Health Act* requirement for recognition of federal contributions in support of insured and extended health care services and a section outlining the range of extended health care services in their jurisdiction; where extended health care includes nursing home intermediate care services, adult residential care services, home care services and ambulatory health care services.

Provinces and territories were also requested to include in their narrative a list of published documents and materials that relate to the five criteria of the *Canada Health Act*, as well as to the recognition condition. These documents, or additional materials, include health care insurance legislation, regulations, audit and evaluation reports, annual reports of health departments and other documents that permit Health Canada to ensure that provinces and territories are in compliance with the criteria and conditions of the *Canada Health Act*.

In order to assist provincial and territorial health department officials in preparing clear, consistent and complete information for their government's submission to the Canada Health Act Annual Report, Health Canada prepared a *Users' Guide for Submissions to Health Canada*. This Guide was developed through discussion with representatives from each province and territory and specifies the information requested for each criterion of the Act. In addition, the Users' Guide provides examples drawn from previous provincial and territorial submissions to illustrate the organization and type of information being sought.

Following a federal/provincial/territorial teleconference in June, 2002, Health Canada provided each province and territory with recommendations for sections from their previous plan descriptions needing further clarification and suggestions for amplification to ensure that the 2001-2002 submissions reflect a complete and accurate picture of provincial and territorial health care plans. In addition, provinces and territories were offered technical advice and assistance in the completion of their submissions through follow-up phone calls and teleconferences.

Please note that for the *Canada Health Act Annual Report, 2001-2002*, Quebec submitted a description of their health insurance plan according to the format used previous to fiscal year 1999-2000. Quebec does not provide information in the manner and detail requested by Health Canada, as noted in the preface to Quebec's narrative.

During 2001-2002, provinces and territories continued to implement initiatives to ensure and enhance access by residents to insured health services. Examples of this include:

- targeted funding for primary health care in Newfoundland and Labrador that will ensure that residents receive the right service by the right provider at the right time;
- the creation of the Out-of-Province Medical Transport Support Program in Prince Edward Island to cover a portion of the cost of out-of-province ground ambulance transportation, which reduces the user fee for eligible Island residents who need specialized medical care outside the province.

- an increase in Nova Scotia in general practice medical training, ongoing recruitment activities and funding to create a re-entry program for general practitioners wishing to enter specialty training after completing two years of general practice service in the province;
- the introduction of new MRI machines in two regions of New Brunswick and the introduction of mobile MRI services in three other regions;
- Ontario increased cardiac and renal services through implementation of new and expanded systems;
- an initiative in Manitoba to end hallway medicine by opening new beds, improving admission and discharge procedures, expanding community-based services, strengthening prevention programs like flu immunization and increasing home care and adult day-care programs;
- a strategy in Saskatchewan to improve the management of surgical wait lists to ensure fair, timely access to surgery;
- significant increases in Alberta's medical school and medical residency seat numbers. These included the addition of 54 new medical school entry positions in Alberta's two facilities of medicine, and creation of the Alberta International Medical Graduate (AIMG) Program and the Alberta Rural Family Medicine Network (ARFMN);
- strategies in British Columbia which were developed to reduce demand for services by redirecting low priority calls to other resources, such as the BC Health Guide NurseLine and Poison Control. This will ensure optimal use of specialized skills and resources;
- an initiative in the Yukon to implement real-time video to support access and delivery of services between outlying rural communities with Whitehorse and Whitehorse with outside centres in British Columbia or Alberta;
- improvements in entry level training programs targeted at northerners in general and at northern Aboriginal people as key providers of health and social care services in the Northwest Territories. This will decrease the reliance of NWT on other jurisdictions for key health and social care professionals; and
- medical travel assistance in Nunavut, intended to break down the barrier posed by distance and cost of travel for diagnosis and treatment. Interpretation services are also provided to patients if required in any health setting.

Newfoundland and Labrador

Introduction

Fourteen regional boards operate most health services in Newfoundland and Labrador. Of these, eight are institutional health boards, four are health and community services boards and two are integrated boards, delivering both institutional and community services. Included in the eight institutional boards is a provincial board for cancer services and a regional board for nursing homes, both located in St. John's.

The provincial government appoints health boards, whose members serve as volunteers. These boards are responsible for delivering health services to their regions and, in some cases, to the Province as a whole, interacting with the public to determine health needs. The boards receive their funding from the provincial government, to which they are accountable. The Department of Health and Community Services provides the boards with policy direction and monitors programs and services.

In Newfoundland and Labrador almost 20,000 health care providers and administrators provide health services to the 512,000 residents.

Planning for the future of the Province's health care system requires a clear understanding of the main challenges. These are:

- rapidly rising costs that threaten the affordability of Medicare;
- an aging population that generally requires more services than younger groups;
- the cost of new drugs and advanced technologies;
- rising salaries and fees in other provinces that cause pressure for raises in Newfoundland and Labrador;
- the need for more investment in early intervention and prevention in order to promote wellness;
- increased demands for home support services; and
- a need to expand community mental health services.

Planning will include decision making based on the principles of accessibility, quality, accountability and sustainability. The major planning areas include health services structure, funding, human resources, a wellness focus, the health services delivery model, and accountability.

Additional information on health and health care in Newfoundland and Labrador is available from the website of the Department of Health and Community Services at:

www.gov.nf.ca/health/

Highlights of Initiatives in 2001-2002

The Government of Newfoundland and Labrador made a significant investment in health care in 2001-2002, raising health and community services expenditures to approximately 45 percent of all government program expenditures. New spending of $114 million was committed for 2001-2002.

The total Health and Community Services budget for 2001-2002 was $1.4 billion, the largest budget of all government departments in the Province.

In 2001-2002, the Government allocated $27.6 million to modernize diagnostic and therapeutic equipment in health facilities. Of this amount, $8.6 million came from the federal government as part of the First Ministers' Agreement on Health Renewal. Purchases included primarily diagnostic and other clinical services equipment.

Approximately $500 million has been committed over the past six years for new health facilities and renovations of existing health facilities.

In October 2001, regional health forums were held across the Province. Four hundred health professionals along with municipal and community leaders helped analyze the major health issues and shape the principles that will guide health care decision making in the future. Additional information is available from the web site at:

www.gov.nf.ca/health/healthforums2001

Targeted funding of $2.4 million was allocated for innovations in primary health care as part of the September 2000 agreement by First Ministers on Health Renewal. This four-year program will encourage new approaches that simplify and coordinate primary health care services so people receive the right service by the right provider at the right time. These initiatives encourage health professionals to work in interdisciplinary teams to provide improved and co-ordinated services and relieve pressures elsewhere in the system, in particular emergency rooms.

In 2001-2002, the Government provided $650,000 to pilot a new model for haemodialysis services in one of the health regions. This community-based satellite service will be evaluated to determine the feasibility of implementing this model of care in other regions.

Approximately $4 million was expended on programs and services to ensure that children get a good start in life through the Early Childhood Development Initiative.

Total expenditures for occupational reclassifications of registered nurses, licensed practical nurses, social workers and other allied health professionals, along with general salary increases, was $29.7 million.

One million dollars was committed in 2001-2002 for increases in subsidies and rates for the personal care home industry.

Over three million (i.e. $3.1) dollars in new funding was allocated to increase the level of service in the Province's cardiac care program with $2.4 million allocated to increase the cardiac surgery program to 20 cases per week and $710,000 provided to increase the level of cardiac catheterization.

The pharmacist dispensing fees for income support clients were increased to $6.50, fully restoring them to the level prior to the 1996 budget. This measure will cost $2.1 million.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

Health care insurance plans managed by the Department of Health and Community Services include the Hospital Insurance Plan and the Medical Care Plan (MCP). Both plans are non-profit and are audited by the Auditor General of the Province.

The *Hospital Insurance Agreement Act*, amended in 1994, is the legislation that enables the Hospital Insurance Plan. The Act provides that the Minister may make Regulations for the provision of insured services upon uniform terms and conditions to residents of the Province under the conditions specified in the *Canada Health Act* and Regulations.

The *Medical Care Insurance Act* (1999) was assented to on December 14, 1999 and came into force on April 1, 2000. This Act empowers the Minister to administer a plan of medical care insurance for residents of the Province. It allows for the development of Regulations to ensure that the provisions of the statute meet the requirements of the *Canada Health Act* as it relates to the administration of the medical care insurance plan.

On May 24, 2001, the *Medical Care Insurance Act* (1999) was amended to allow payment to a professional medical corporation for insured services rendered to a beneficiary. Previously only an individual physician could submit accounts. A professional medical corporation is subject to the same review and audit process that would be applied to an individual physician.

There have been no legislative amendments to the *Hospital Insurance Agreement Act* in 2001-2002.

The MCP facilitates the delivery of comprehensive medical care to all residents of the Province by implementing policies, procedures, and systems that permit appropriate compensation to providers for the rendering of insured professional services.

The MCP operates in accordance with the provisions of the *Medical Care Insurance Act,* (1999) and Regulations, and in compliance with the criteria of the *Canada Health Act*.

1.2 Reporting Relationship

The Department of Health and Community Services is mandated with the administration of the Hospital Insurance and Medical Care Plans. The Department reports on these plans through the regular legislative processes, e.g., Public Accounts.

During 2001-2002 work has continued on implementation of the Government's Accountability Framework. The focus has been on development of an appropriate method of strategic planning, to achieve uniformity in approach from public bodies and, in the case of health boards, congruence between their respective strategic plans and a Strategic Health Plan for the Province, currently under development. Workshops have been developed to guide boards in the preparation of new or revised strategic plans.

The Province has published *Excellence in Governance: A Handbook for Public Sector Bodies* (2002). This publication serves as a ready reference for all members of governing bodies, and all health board trustees in the Province have been supplied with a copy. Orientation and training modules have been drafted corresponding to chapters in the handbook, and will be made available to health boards for education and development.

1.3 Audit of Accounts

Each year the Province's Auditor General performs an independent examination of provincial public accounts. MCP expenditures are now considered a part of the public accounts. The Auditor General has full and unrestricted access to the MCP records.

Hospital boards are subject to Financial Statement Audits, Reviews, and Compliance Audits. Financial Statement Audits are performed by independent auditing firms that are selected by the boards under the terms of the *Public Tendering Act*. Review engagements, compliance audits and physician audits are carried out by personnel from the Department of Health and Community Services under the authority of the Newfoundland *Medical Care Insurance Act* (1999). Physician records are reviewed to ensure that the record supports the service billed and that the service is insured under the Medical Care Plan.

Beneficiary audits are performed by personnel from the Department of Health and Community Services under the *Medical Care Insurance Act* (1999). Individuals are randomly selected on a bi-weekly basis.

2.0 Comprehensiveness

2.1 Insured Hospital Services

The *Hospital Insurance Agreement Act* (1990) and the Hospital Insurance Regulations 742/96 (1996) provide for insured hospital services in Newfoundland and Labrador.

Insured hospital services are provided for in- and out-patients in 32 facilities and 18 nursing stations. Insured in-patient services include:

- ☐ accommodation and meals at the standard ward level;
- ☐ nursing services;
- ☐ laboratory, radiological and other diagnostic procedures;
- ☐ drugs, biologicals and related preparations;
- ☐ medical and surgical supplies, operating room, case room and anaesthetic facilities;
- ☐ rehabilitative services (e.g., physiotherapy, occupational therapy, speech language pathology and audiology);
- ☐ out-patient and emergency visits; and
- ☐ day surgery.

Fourteen regional boards operate most health services in Newfoundland and Labrador. Of these, eight are institutional health boards, four are health and community services boards and two are integrated boards, delivering both institutional and community services. Included in the eight institutional boards is a provincial board for cancer services and a regional board for nursing homes, both located in St. John's.

In total 15 hospitals, 17 community health centres and 18 nursing stations provide insured hospital services.

Coverage policy for insured hospital services is linked to the coverage policy for insured physician services, although there is no formalized process. Ministerial direction is required to add a hospital service to the list of insured services. The Department of Health and Community Services manages the process.

No services were added or deleted in 2001-2002 to the list of insured hospital services covered by the Newfoundland and Labrador health care insured plan.

2.2 Insured Physician Services

The enabling legislation for insured physician services is the *Medical Care Insurance Act* (1999).

Other governing legislation under the *Medical Care Insurance Act* include:

- ☐ the Medical Care Insurance Insured Services Regulations;
- ☐ the Medical Care Insurance Beneficiaries and Inquiries Regulations; and
- ☐ the Medical Care Insurance Physician and Fees Regulations.

Licensed medical practitioners are allowed to provide insured physician services under the insurance plan. A physician must be licensed by the Newfoundland Medical Board to practise in the Province.

In 2001-2002, 952 physicians provided insurance services in the Province.

Physicians can choose not to participate in the health care insurance plan as outlined in section 12(1) of the *Medical Care Insurance Act* (1999), namely:

"Where a physician providing insured services is not a participating[1] physician, and the physician provides an insured service to a beneficiary, the physician is not subject to this Act or the Regulations relating to the provision of insured services to beneficiaries or the payment to be made for the services except that he or she shall:

> (a) before providing the insured service, if he or she wishes to reserve the right to charge the beneficiary for the service an amount in excess of that payable by the Minister under this Act, inform the beneficiary that he or she is not a participating physician and that the physician may so charge the beneficiary; and
>
> (b) provide the beneficiary to whom the physician has provided the insured service with the information required by the Minister to enable payment to be made under this Act to the beneficiary in respect of the insured service."

For purposes of the Act, the following services are covered:

- ☐ all services properly and adequately provided by physicians to beneficiaries suffering from an illness requiring medical treatment or advice;
- ☐ group immunizations or inoculations carried out by physicians at the request of the appropriate authority; and
- ☐ diagnostic and therapeutic x-ray and laboratory services in facilities approved by the appropriate authority that are not provided under the *Hospital Insurance Agreement Act* and Regulations made under the Act.

There are no limitations on the services covered, provided they qualify under one or more of the conditions listed above.

No services were added or deleted in 2001-2002 to the list of insured physician services covered by the Newfoundland and Labrador health care insurance plan.

Ministerial direction is required to add a physician service to the list of insured services. This process is initiated following consultation by the Department with various stakeholders, including the provincial medical association. The Department of Health and Community Services manages the process and public consultation is involved.

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[1] The *Medical Care Insurance Act* (1999) defines "participating physician" as a physician who has not made an election, under subsection 7(3), to collect payments in respect of insured services rendered by him or her to residents, otherwise than from the Minister.

2.3 Insured Surgical-Dental Services

The provincial Surgical Dental Program is a component of the MCP. Surgical-dental treatments properly and adequately provided to a beneficiary and carried out in a hospital by a dentist are covered by the MCP if the treatment is of a type specified in the Surgical-Dental Services Schedule.

All dentists licensed to practise in Newfoundland and Labrador and who have hospital privileges are allowed to provide surgical-dental services. The dentist's licence is issued by the Newfoundland Dental Licensing Board.

Dentists may opt out of the Plan. The dentists must advise the patient of their opted-out status, stating the fees expected, and providing the patient with a written record of services and fees charged. One dentist is currently in an opted-out category.

As the Surgical Dental Program is a component of the MCP, management of the Program is linked to the MCP with regard to changes to the list of insured services. The Department of Health and Community Services manages the process.

Addition of a surgical-dental service to the list of insured services must be approved by the Department of Health and Community Services.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Hospital services not covered by the Plan include:

- preferred accommodation at the patient's request;
- cosmetic surgery and other services deemed to be medically unnecessary;
- ambulance or other patient transportation prior to admission or upon discharge;
- private duty nursing arranged by the patient;
- non-medically required x-rays or other services for employment or insurance purposes;
- drugs (except anti-rejection and AZT drugs) and appliances issued for use after discharge from hospital;
- bedside telephones, radios or television sets for personal, non-teaching use;
- fibreglass splints;
- services covered by Workers' Compensation legislation or by other federal or provincial legislation; and
- services relating to therapeutic abortions performed in non-accredited facilities or facilities not approved by the Newfoundland Medical Board.

The use of the hospital setting for any services deemed not insured by the Medicare Plan would also be uninsured under the Hospital Insurance Plan.

For purposes of the *Medical Care Insurance Act* (1999), the following is a list of non-insured physician services:

- any advice given by a physician to a beneficiary by telephone;
- the dispensing by a physician of medicines, drugs or medical appliances and the giving or writing of medical prescriptions;
- the preparation by a physician of records, reports or certificates for or on behalf of, or any communication to or relating to, a beneficiary;
- any services rendered by a physician to the spouse and children of the physician;
- any service to which a beneficiary is entitled under an Act of the Parliament of Canada, an Act of the Province of Newfoundland and Labrador, an Act of the legislature of any province of Canada, or any law of a country or part of a country;
- the time taken or expenses incurred in travelling to consult a beneficiary;
- ambulance service and other forms of patient transportation;
- acupuncture and all procedures and services related to acupuncture, excluding an initial assessment specifically related to diagnosis of the illness proposed to be treated by acupuncture;
- examinations not necessitated by illness or at the request of a third party except as specified by the appropriate authority;

- ☐ plastic or other surgery for purely cosmetic purposes, unless medically indicated;
- ☐ testimony in a court;
- ☐ visits to optometrists, general practitioners and ophthalmologists solely for the purpose of determining whether new or replacement glasses or contact lenses are required;
- ☐ the fees of a dentist, oral surgeon or general practitioner for routine dental extractions performed in hospital;
- ☐ fluoride dental treatment for children under four years of age;
- ☐ excision of xanthelasma;
- ☐ circumcision of newborns;
- ☐ hypnotherapy;
- ☐ medical examination for drivers;
- ☐ alcohol/drug treatment outside of Canada;
- ☐ consultation required by hospital Regulation;
- ☐ therapeutic abortions performed in the Province at a facility not approved by the Newfoundland Medical Board;
- ☐ sex reassignment surgery, when not recommended by the Clarke Institute of Psychiatry;
- ☐ *in-vitro* fertilization and OSST (ovarian stimulation and sperm transfer);
- ☐ reversal of previous sterilization procedure;
- ☐ surgical diagnostic or therapeutic procedures not provided in facilities other than those listed in the Schedule to the *Hospitals Act* or approved by the appropriate authority under paragraph 3(d); and
- ☐ other services not within the ambit of section 3 of the Act.

All diagnostic services (e.g., laboratory services and x-ray) are performed within public facilities in the Province. Hospital policy on access ensures that third parties are not given priority access.

Medical goods and services that are implanted and associated with an insured service are provided free of charge to the patient and are consistent with national standards of practise. Patients retain the right to financially upgrade the standard medical goods or services. Standards for medical goods are developed by the hospitals providing those services in consultation with service providers.

Surgical-Dental and other services not covered by the Surgical-Dental Program are the dentist's, oral surgeon's or general practitioner's fees for routine dental extractions in hospital.

3.0 Universality

3.1 Eligibility

Residents of Newfoundland and Labrador are eligible for coverage under the provincial health care program.

The *Medical Care Insurance Act* (1999) defines a "resident" as a person lawfully entitled to be or to remain in Canada, who makes his or her home and is ordinarily present in the Province, but does not include tourists, transients or visitors to the Province.

The Medical Care Insurance Beneficiaries and Inquiries Regulations (Regulation 20/96) identify those residents eligible to receive coverage under the plans. As the administrator of the Regulations, the MCP has established rules to ensure that the Regulations are applied consistently and fairly in processing applications.

Persons not eligible for coverage under the plans include:

- ☐ students and their dependants already covered by another province or territory;
- ☐ dependants of residents if covered by another province or territory;
- ☐ certified refugees and refugee claimants and their dependants;
- ☐ foreign workers with Employment Authorizations and their dependants who do not meet the established criteria;
- ☐ foreign students and their dependants;
- ☐ tourists, transients, visitors and their dependants;
- ☐ Canadian Armed Forces and Royal Canadian Mounted Police personnel;
- ☐ inmates of federal prisons; and

- ☐ armed forces personnel of other countries who are stationed in the Province.

3.2 Registration Requirements

Registration under the Medical Care Plan and possession of a valid MCP card are required in order to access insured services. New residents are advised to apply for coverage as soon as possible upon arrival in Newfoundland and Labrador.

It is the parent's responsibility to register a newborn or adopted child. The parents of a newborn child will be given a registration application upon discharge from hospital. Applications for newborn coverage will require, in most instances, a parent's valid MCP number. A birth or baptismal certificate will be required where the child's surname differs from the parents' surname.

Applications for coverage of an adopted child will require a copy of the official adoption documents, the birth certificate of the child, or a Notice of Adoption Placement from the Department of Health and Community Services. Applications for coverage of a child adopted outside Canada will require Permanent Resident documents for the child.

As of April 30, 2002 there were 565,309 active beneficiaries registered with the Medical Care Plan.

3.3 Other Categories of Individual

Foreign workers and clergy, and dependants of North Atlantic Treaty Organization personnel are eligible for benefits. Holders of Minister's Permits are also eligible, subject to Plan approval.

4.0 Portability

4.1 Minimum Waiting Period

Insured persons moving to Newfoundland and Labrador from other provinces or territories are entitled to coverage on the first day of the third month following the month of arrival.

Persons arriving from outside Canada to establish residence are entitled to coverage on the day of arrival. The same applies to discharged members of the Canadian Forces and the Royal Canadian Mounted Police, and released inmates of federal penitentiaries. For coverage to be effective, however, registration is required under the Medical Care Plan. Immediate coverage is provided to persons from outside Canada who are authorized to work in the Province for one year or more.

4.2 Coverage During Temporary Absences In Canada

Newfoundland and Labrador is a party to the Agreement on Eligibility and Portability with regards to matters pertaining to portability of insured services in Canada.

Sections 12 and 13 of the Hospital Insurance Regulations (1996) define portability of hospital coverage during temporary absences both within and outside Canada. Portability of medical coverage during temporary absences both within and outside Canada is defined in Department of Health and Community Services policy.

Eligibility policy for insured hospital services is linked to the eligibility policy for insured physician services, although there is no formalized process.

Coverage is provided to residents during temporary absences within Canada. The Province has entered into formal agreements, i.e. the Hospital Reciprocal Agreement, with other provinces and territories for the reciprocal billing of insured hospital services. In-patient costs are paid at standard rates approved by the host province or territory. In-patient high-cost procedures and out-patient services are payable based on national rates agreed to by provincial and territorial health plans.

With the exception of Quebec, medical services incurred in all provinces or territories are paid through the Medical Reciprocal Agreement at host province or territory rates. Claims for medical services received in Quebec are submitted by the patient to the MCP for payment at host province rates.

In order to qualify for out-of-province coverage, a beneficiary must comply with the legislation and

MCP rules regarding residency in Newfoundland and Labrador. A resident must reside in the Province at least four consecutive months in each 12 month period to qualify as a beneficiary. Generally, the rules regarding medical and hospital care coverage during absences include:

- prior to leaving the Province for extended periods, a resident must contact the MCP to obtain an out-of-province coverage certificate;
- beneficiaries leaving for vacation purposes may receive an initial out-of-province coverage certificate of up to 12 months' duration. Upon return, beneficiaries are required to reside in the Province for a minimum four consecutive months. Thereafter, certificates will only be issued for up to eight months' coverage;
- students leaving the Province may receive a certificate, renewable each year, provided they submit proof of full-time enrolment in a recognized school located outside the Province;
- persons leaving the Province for employment purposes may receive a certificate of up to 12 months' coverage. Verification of employment may be required;
- persons must not establish residence in another province, territory, or country while maintaining coverage under the Newfoundland Medical Care Plan;
- for out-of-province trips of 30 days or less, an out-of-province coverage certificate is not required, but will be issued upon request;
- for out-of-province trips lasting more than 30 days, a certificate is required as proof of a resident's ability to pay for services while outside the Province; and
- failure to request out-of-province coverage or failure to abide by the residency rules may result in the resident having to pay the entire cost of any medical or hospital bills incurred outside the Province.

Insured residents moving permanently to other parts of Canada are covered up to and including the last day of the second month following the month of departure. Coverage is immediately discontinued when residents move permanently to other countries.

4.3 Coverage During Temporary Absences Outside Canada

The Province provides coverage to residents during temporary absences outside Canada. Out-of-country insured hospital in- and out-patient services are covered for emergency, sudden illness and elective procedures at established rates. Hospital services will be considered under the Plan when the insured services are provided by a recognized facility (licensed or approved by the appropriate authority within the state or country in which the facility is located) outside Canada. The maximum amount payable by the Government's hospitalization plan for out-of-country in-patient hospital care is $350 per day if the insured services are provided by a community or regional hospital. Where insured services are provided by a tertiary care hospital (a highly specialized facility), the approved rate is $465 per day. The approved rate for out-patient services is $62 per visit and hæmodialysis is $220 per treatment. The approved rates are paid in Canadian funds.

Physician services are covered for emergencies or sudden illness, and are also insured for elective services not available in the Province or within Canada. Physician services are paid at the same rate as would be paid in Newfoundland and Labrador for the same service. If the services are not available in Newfoundland and Labrador, they are usually paid at Ontario rates, or at rates that apply in the Province in which they are available.

4.4 Prior Approval Requirement

Prior approval is not required for medically necessary insured services provided by accredited hospitals or licensed physicians in the other provinces and territories.

If a resident of the Province has to seek specialized hospital care outside the country because the insured service is not available in Canada, the provincial health insurance plan will pay the costs of services necessary for the patient's care. However, it is necessary in these circumstances for such referrals to receive prior approval from the Department of Health and Community Services. The referring physicians must contact the Department or the Medical Care Plan for prior approval.

Prior approval is not required for physician services, however, it is suggested that physicians obtain prior approval from the Plan so that patients may be made aware of any financial implications. General practitioners and specialists may request prior approval on behalf of their patients. Prior approval is not granted for out-of-country treatment of elective services if the service is available in the Province or elsewhere within Canada.

5.0 Accessibility

5.1 Access to Insured Health Services

Access to insured health services in Newfoundland and Labrador is provided on uniform terms and conditions. There are no co-insurance charges for hospital services and no extra-billing by physicians in the Province.

5.2 Access to Insured Hospital Services

As of March 31, 2002, Newfoundland and Labrador had 1,670 staffed hospital beds in 15 hospitals, 17 community health centres and 18 nursing stations.

The supply of health professionals is an issue of high priority in this province, especially in rural areas. Through the Provincial Health and Community Services Human Resource Planning Committee, a major human resource planning exercise has been underway for the last few years. The work of this committee will result in a comprehensive set of recommendations to deal with many of the significant issues. The exercise will identify a planning model to provide five-year forecasts of the demand and supply of various health human resources.

Due to the increasing number of retirements in the nursing profession, the planning exercise has already identified the need to immediately increase nursing school enrolments. This will help secure an appropriate supply of nurses for the future. Issues of absenteeism and sick leave have also been highlighted for further consideration.

There is a health care workforce of nearly 20,000 individuals in Newfoundland and Labrador, half of which belongs to regulated professional groups. A summary of the major allied health professions in the Province follows.

Profession	Number of Unionized Employees
Registered Nurse	5,070
Licensed Practical Nurse	2,790
Social Worker	662
Pharmacist	73
Physiotherapist	110
Occupational Therapist	106
Psychologist	59
Medical Lab/X-ray	695
Dietitian	67
Speech Language Pathologist	40
Audiologist	16

The number of Nurse Practitioner positions has now increased to approximately 50, with a small number of specialist positions in tertiary care. Licensed practical nurse graduate numbers have risen by 38 percent from 1997 to 2001. Other initiatives include nursing bursaries in 2000 and 2001; nurse practitioner student bursaries; a Northern Incentive package for nurses in remote and northern locations, including retention bonuses and sabbatical leave; a three-year pilot to assist with rural and remote clinical placements of nursing students; and scholarships.

Research is ongoing with projects funded by Human Resources Development Canada and the Canadian Health Services Research Foundation. Projects include impacts of health care restructuring, evaluation of implementing the nurse practitioner role (completed and released December 2001), and studies of facilities, resources, preceptors, clinical placements, continuing and advanced education and numbers of seats required as part of a long-term education plan. Newfoundland and Labrador is a member of the Atlantic Consortium for Research Utilization in Nursing and is participating as a pilot site with Health Canada to test a human resource simulation model for Registered Nurses and Licensed Practical Nurses.

The Canadian Institute for Health Information's Registered Nurses Database indicates that in 2001, the ratio of Registered Nurses to population in Newfoundland and Labrador (102/10,000) was higher than the ratio in all other provinces and higher than the rate for Canada as a whole (74.3/10,000). The RN workforce in Newfoundland and Labrador continued to be the youngest in Canada, at an average age of 40.1 years in 2001. Despite the high Registered Nurse per 10,000 population ratio, some Health Boards have experienced shortages of nursing staff.

Shortages continue in other professional groups, such as pharmacy, physiotherapy, speech language pathology, audiology and occupational therapy, as well as psychology. Focused recruitment and incentive programs such as bursaries and seat purchases are in place, and new approaches continue to be developed.

With regard to the availability of selected diagnostic, medical, surgical and treatment equipment and services in facilities providing insured hospital services:

- Magnetic Resonance Imaging (MRI) is located in St. John's only;
- Computed Tomography (CT) scanners are available in St. John's, Carbonear, Clarenville, Gander, Grand Falls/Windsor, Corner Brook, St. Anthony and Happy Valley/Goose Bay;
- renal dialysis is provided in St. John's, Clarenville, Grand Falls/Windsor, Corner Brook and Stephenville;
- cancer treatment is provided at the Dr. H. Bliss Murphy Cancer Centre, St. John's, and satellite clinics in Gander, Grand Falls/Windsor, Corner Brook and St. Anthony;
- approximately 80 percent of surgery services are provided in St. John's, Gander, Grand Falls/Windsor, Corner Brook and St. Anthony. A full range of basic and some sub-specialty surgical services is available in all locations. Tertiary surgery, e.g., trauma, cardiac, and neuro, is available in St. John's only; and
- an additional 20 percent of surgery services is provided in six mid-sized hospitals at Carbonear, Clarenville, Burin, Stephenville, Happy Valley/Goose Bay and Labrador City. These facilities offer basic surgical services.

An additional $400,000 dollars was allocated for the Medical Transportation Assistance Program to provide financial help to people who incur high costs accessing medical and hospital treatment.

5.3 Access to Insured Physician and Dental-Surgical Services

The number of physicians practising in the Province is relatively stable. The Department of Health and Community Services is working with regional health boards to develop a human resource plan for physicians based on the principle of access to services.

Improvement in salary scales and retention bonuses for salaried physicians reflective of geography have been implemented to improve rural recruitment. Premiums on hospital-based services provided by general practitioners in rural hospitals have also been applied.

Service levels and accessibility (wait time) issues are monitored by regional health boards with adjustments made as required, such as increasing the number of cardiac surgeries performed weekly.

During 2001-2002, 14 new physicians had at some point received financial assistance from the Department of Health and Community Services through the Travelling Fellowship Program, the Medical Specialist Resident Bursary Program, the Medical Student and Resident Practice Incentive Program or the Psychiatry Resident Bursary Program.

A new Provincial Physician Recruitment office was opened at the Memorial University of Newfoundland Medical School.

With regard to surgical-dental services, four certified dental surgeons and one non-certified oral surgeon practised in the Province. A total of 21 general-practice dentists have hospital privileges.

5.4 Physician Compensation

The legislation governing payments to physicians and dentists for insured services is the *Medical Care Insurance Act (1999)*.

Compensation agreements are negotiated between the provincial government and the Newfoundland and Labrador Medical Association, with involvement of the Newfoundland and Labrador Health Boards Association, using traditional and formalized negotiation methods. The dispute resolution mechanism agreed to is mediation. The term of the current agreement is from April 1, 1999 to September 30, 2002.

The current methods of remuneration to compensate physicians for providing insured health services include fee-for-service, salary, contract, and sessional block funding.

5.5 Payments to Hospitals

The Department of Health and Community Services is responsible for funding Regional Boards for ongoing operations and capital purchases. Funding for insured services is provided to the Boards as an annual global budget and is distributed in 12 monthly advance payments. Payments are made to Regional Boards in accordance with the *Hospital Insurance Agreement Act* (1990) and the *Hospitals Act*. As part of their accountability to the Government, Boards are required to meet the Department's annual reporting requirements, which include audited financial statements and other financial and statistical information. The global budgeting process devolves the budget allocation authority, responsibility, and accountability to all appointed Boards in the discharge of their mandates.

Throughout the fiscal year, the Health Boards may forward additional funding requests to the Department of Health and Community Services for changes in program areas or increased workload volume. These requests will be reviewed, and if approved by the Department, funded at the end of each fiscal year. Any adjustments to the annual funding level, such as for negotiated salary increases, additional approved positions or program changes are funded based on the implementation date of such increases and the cash flow requirement in a given fiscal year.

Boards are continually facing challenges in addressing increased demands when costs are rising, staff workloads are increasing, patient expectations are higher, and new technology introduces new demands for time, resources, and funding. Boards are continuing to work with the Department of Health and Community Services to address these issues and provide effective, efficient and quality health services.

6.0 Recognition Given to Federal Transfers

Funding provided by the federal government through the Canada Health and Social Transfer has been recognized and reported by the Government of Newfoundland and Labrador through press releases, government websites, and various other documents. For fiscal 2001-2002 these documents included:

- ❑ the 2001-2002 Public Accounts Volume I,
- ❑ the Estimates 2002-2003, and
- ❑ the Budget Speech 2002.

These reports were tabled by the Government to the House of Assembly, are publicly available to Newfoundland and Labrador residents and have been shared with Health Canada for information purposes.

7.0 Extended Health Care Services

Newfoundland and Labrador has established long-term residential and community-based programs as alternatives to hospital services. These programs are provided by seven Regional Boards. Services include the following:

Nursing Home Services

Long-term residential accommodations are provided for clients requiring high levels of nursing care in 18 community health centres and

19 nursing homes. There are approximately 2,800 beds located in these 37 facilities. Residents pay a maximum of $2,800 per month based on each client's assessed ability to pay, using provincial financial assessment criteria. The balance of funding required to operate these facilities is provided by the Department of Health and Community Services.

Personal Care Homes

Persons requiring protective oversight or minimal assistance with activities of daily living can avail themselves of residential services in personal care homes. There are approximately 2,400 beds located in 103 homes across the Province. These homes are operated by the private for-profit sector. Residents pay a maximum of $1,018 per month, based on an individual client assessment using standardized financial criteria. In 2001-2002, an additional 136 subsidies were provided under a five-year plan to enable more elderly people to access this type of residential service.

Home Care Services

Home care services include professional and non-professional supportive care to enable people to remain in their own homes for as long as possible without risk. Professional services include nursing and some rehabilitative programs. These services are publicly funded and delivered by staff employed with six Regional Boards.

Non-professional services include personal care, household management, respite and behavioural management. These services are delivered by home support workers through agency or self-managed care arrangements. Eligibility for non-professional services is determined through a client financial assessment using provincial criteria. The 2001 ceiling for home support services was $2,707 for seniors and $3,875 for persons with disabilities.

Special Assistance Program

The Special Assistance Program is a provincial program that provides basic supportive services to assist financially eligible clients in the community with activities of daily living. The benefits include access to health supplies, oxygen, orthotics and other equipment.

Drug Programs

The Senior Citizens' Drug Subsidy Program is provided to residents over 65 years of age who receive the Guaranteed Income Supplement and who are registered for Old Age Security benefits. Eligible individuals are provided coverage for the ingredient portion of the prescription. Any additional cost, such as dispensing fees, are the client's responsibility. Income support recipients are eligible for the Social Services Drug Plan, which covers the full cost of benefit prescription items, including markup amount and dispensing fee.

Other Programs

The Department of Health and Community Services administers the Emergency Air and Road Ambulance Programs through the Emergency Health Services Division. The Air Ambulance Program provides transportation and medical care to patients within the Province of Newfoundland and Labrador, and to hospitals outside the Province where warranted. Air Ambulance will also transport patients, medical staff and equipment to and from isolated communities when required. The Road Ambulance Program provides medical care and transportation to residents accessible by road at a reasonable cost to the user. User fees are charged for both Road and Air Ambulance Program use.

Residents who travel by commercial air to access medically necessary insured services that are not available within their area of residence or within the Province, may qualify for financial assistance under the Medical Transportation Assistance Program. This program is administered by the Department of Health and Community Services. Kidney donors and bone marrow/stem-cell donors are eligible for financial assistance, as administered by the Health Care Corporation of St. John's, when the recipient is a Newfoundland and Labrador resident eligible for coverage under the Newfoundland Hospital Insurance and Medical Care Plans.

The Dental Health Plan incorporates a children's dental component and a social assistance component. The children's program covers the following dental services for all children up to and including the age of 12: examinations at 6-month intervals; cleanings at 12-month intervals; fluoride applications for children aged 6 to 12 at 12-month intervals; x-rays (some limitations); fillings and extractions; and some other specific procedures that require approval before treatment. These basic services are also available under the income support component to recipients aged 13 to 17 years. Adults receiving social assistance are eligible for emergency care and extractions. Beneficiaries covered under the Dental Health Plan must pay a co-payment amount directly to the dentist for each service provided (e.g., fillings, extractions, etc), with the exception of examinations, dental cleanings, fluoride applications, radiographs, and retention pins for fillings. In circumstances where the beneficiary is receiving income support the co-payment is paid by the Dental Health Plan.

Prince Edward Island

Introduction

The Ministry of Health and Social Services is a very large and complex system of integrated services that protect, maintain and improve the health and well-being of Islanders.

The continued sustainability of the system is a primary concern. Spending on health and social services has grown rapidly in recent years to 42 percent of total provincial government program expenditures. At this rate of growth, spending could reach 50 percent of overall spending within the next five years. The availability of health professionals is also affecting our ability to sustain services.

We are concerned about the high rate of chronic conditions in our province; conditions such as cardiovascular disease, cancer, diabetes, and mental illness. Wellness initiatives will assist Islanders to increase acceptance of responsibility for their health and reach their full health potential. This will be achieved through community partnerships to promote healthy lifestyles and reduce risk factors for chronic disease, and through increased access to primary health services that support disease prevention and management.

Recruitment, retention and human resource planning will remain a priority to ensure an adequate supply and appropriate mix of health and social service professionals to meet changing needs. Retention initiatives are supported by comprehensive workplace wellness programs to promote organizational excellence, positive personal health practices, and safe, positive workplaces.

Overview of the Health and Social Services System

Prince Edward Island has a publicly administered and funded health system that guarantees universal access to medically necessary hospital and physician services as required by the *Canada Health Act*. Many other health and social services are funded in whole, or in part, by the provincial government.

The system includes a wide range of integrated health and social services such as acute care, addictions, mental health, social assistance and housing services. Some specialty services such as cardiac surgery and neurotrauma services are within the purview of the regional health care system.

Facilities

PEI has two referral hospitals and five community hospitals, with a combined total of 476 beds. Along with seven government manors that house 559 long-term care nursing beds, Islanders have access to an additional 392 beds in private nursing homes. The system also operates several addictions and mental health facilities, 1,170 seniors' housing units, and 461 family housing units.

A new 40-bed provincial addictions facility and a new provincial Cancer Treatment Centre were opened in 2000. Construction of a new $50 million health facility will be completed in Summerside in Fall, 2003. Computed Tomograhpy (CT) scanning and a wide range of diagnostic imaging services are available at the referral hospitals, and new linear accelerator and MRI services are now being established. MRI services will be operational in January, 2003, and linear accelerator services will be operational by May, 2003.

Human Resources

The public sector health and social services workforce has approximately 4,000 employees. Prince Edward Island has 200 health care professionals per 10,000 residents, compared with the national average of 182 per 10,000.[1]

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[1] Canadian Institute for Health Information, 1997

Structure

The system includes the Department of Health and Social Services and five Regional Health Authorities, which are governed by the Regional Health Boards. The Department works with the Regional Health Authorities to establish system goals and objectives, develop policy and outcome standards, and allocate resources. The Regional Health Authorities plan and deliver core programs and services to meet system standards.

Financial Resources

During the past 10 years, provincial spending on health and social services increased from $250 million to more than $372 million in 2001-2002, an average increase of about four percent per year. Increased costs are due to inflation, population growth, new technologies, and the increasing use of services by all age groups.

Major health and social services expenditures are allocated to: Hospital Services, 31 percent; Social Services, 21 percent; Long Term Care, 12 percent; Physician Services, 11 percent; and other services such as Provincial Drug Programs, Public Health Nursing and Addiction Services, 25 percent.

Critical Issues

Supply of health professionals

Maintaining an adequate supply of workers is one of the most critical issues facing the system. Recruitment and retention of skilled employees is expected to be a challenge throughout the labour market in coming years as we experience a major demographic shift. The effect of this trend is being felt first in the health sector, which is labour-intensive and dependent on a specialized workforce, and particularly in less-populated areas like Prince Edward Island. The supply of health professionals is now decreasing as the workforce ages, the number of people retiring increases, and the supply of available graduates declines. To address this issue, the system must increase its focus on workplace wellness and human resource planning to ensure an adequate supply and the right mix of health professionals to meet changing needs.

Public expectation and demand

The demand for services is increasing in almost every area for a variety of reasons, including population growth, the availability of new drugs and technology, and increasing public expectations. Residents are asking for more doctors, nurses, drugs, technology and family services. They want access to care in their own communities, and they are concerned about wait-lists for services. While rising expectations are creating pressure to increase spending on acute care, they are severely limiting the ability of the system to innovate and shift resources to other areas of need.

Increasing public expectation is a very critical issue. Demand alone cannot drive the system. The public must become more informed of reasonable access and the need for real changes in the way services are delivered, particularly in primary health services.

Appropriate access to primary health services

There is growing evidence that investments in primary health services have a great impact on health and sustainability. Primary health services are those that people access first and most often, such as family physician services, public health nursing, screening programs, addiction services and community mental health services.

Personal health practices

Individuals who understand and accept responsibility for health are more able to take control of and improve their health.

People's capacity to accept responsibility for health is influenced by social and economic conditions, and comprehensive strategies are needed to address these conditions. It is critical that the health system increase its capacity to work with others to assist individuals, families and communities to accept responsibility for, and achieve good health.

Aging population

As baby boomers age, we will experience the biggest demographic shift in history. It is expected that the proportion of the population aged 65 and over in Prince Edward Island will increase from 13 percent today to 15 percent in 2011, and to 27 percent in 2036. This will affect the health system in several ways. The incidence of diseases like cancer, heart disease, diabetes and dementia is expected to increase. Demand is expected to rise for acute care, long-term care, home care, mental health and other services. This issue becomes more critical when we consider that the health workforce will be aging at the same time, there will be fewer family members to support their aging parents, and the amount of resources required to sustain services for seniors could negatively affect other government services that support health. It is critical that the health system be prepared to meet these changing needs.

Disease prevention and management

Many diseases are preventable. For example, meningitis can be prevented through vaccination, and the spread of sexually transmitted diseases can be prevented through responsible sexual behaviour. Many chronic conditions are also preventable. Risk factors for cardiovascular disease and cancer can be reduced or eliminated through education and supports that result in a change in lifestyle.

The World Health Organization suggests that diabetes is rising in epidemic proportions worldwide. Prince Edward Island had 17 new cases of diabetes diagnosed each month in the mid-1970s, compared with 45 cases per month in the mid-1990s. It is projected that this number will grow to 65 cases per month in 2006. There is clear and undisputable evidence that efficive blood sugar control can prevent or delay the onset of serious complications from diabetes, such as heart disease, blindness and kidney disease, which have enormous human and financial costs. The prevalence of cancer and diabetes in this province is expected to increase significantly as the population ages. It is imperative that our system step up its efforts to assist Islanders to prevent, delay and manage these conditions.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The Hospital Care Insurance Plan, under the authority of the Minister of Health and Social Services, is the vehicle for the delivery of hospital care insurance in Prince Edward Island. The enabling legislation is the *Hospital and Diagnostic Services Insurance Act* (1988), which insures services as defined under section 2 of the *Canada Health Act*.

Under Part I of the Act, it is the function of the Minister, and the Minister has the power to:

- ensure the development and maintenance throughout the Province of a balanced and integrated system of hospitals and schools of nursing and related health facilities;
- approve or disapprove the establishment of new hospitals and the establishment of, or additions to, related health facilities;
- approve or disapprove all grants to hospitals for construction and maintenance;
- establish and operate, alone or in cooperation with one or more organizations, institutes for training of hospital and related personnel;
- conduct surveys and research programs and to obtain statistics for its purposes;
- approve or disapprove hospitals and other facilities for the purposes of the Act in accordance with the Regulations; and
- subject to the approval of the Lieutenant Governor in Council, to do all other Acts and things that the Minister considers necessary or advisable for carrying out effectively the intent and purposes of the Act.

In addition to the duties and powers enumerated in Part I of the Act, it is the function of the Minister, and the Minister has power to:

- administer the plan of hospital care insurance established by this Act and the Regulations;
- determine the amounts to be paid to hospitals and to pay hospitals for insured services provided to insured persons under the plan of hospital care insurance, and to make retroactive adjustments with hospitals for

under-payment or over-payment for insured services according to the cost as determined in accordance with the Act and the Regulations;

- receive and disburse all monies pertaining to the plan of hospital care insurance;
- approve or disapprove charges made to all patients by hospitals in Prince Edward Island to which payments are made under the plan of hospital care insurance;
- enter into agreements with hospitals outside Prince Edward Island and with other governments and hospital care insurance authorities established by other governments for providing insured services to insured persons;
- to prescribe forms necessary or desirable to carry out the intent and purposes of the Act;
- appoint inspectors and other officers with the duty and power to examine and obtain information from hospital accounting records, books, returns, reports and audited financial statements and reports thereon;
- appoint medical practitioners with the duty and power to examine and obtain information from the medical and other hospital records, including patients' charts with medical records and nurses' notes, reports, and accounts of patients who are receiving or have received insured services;
- appoint inspectors with the duty and power to inspect and examine books, accounts, and records of employers and collectors to obtain information related to the hospital and insurance plan;
- withhold payment for insured services for any insured person who does not, in the opinion of the Minister, medically require such services;
- act as a central purchasing agent for the purchase of drugs, biologicals, or related preparations for all hospitals in the Province; to supervise, check and inspect the use of drugs, biologicals or related preparations by hospitals in the Province and to withhold or reduce payments under the Act to a hospital that does not comply with Regulations respecting the purchasing of drugs, biologicals or related preparations; and
- supervise and ensure the efficient and economical use of all diagnostic or therapeutic aids and procedures used by or in hospitals and to withhold or reduce payments under the Act to a hospital that does not comply with the Regulations respecting the use of such aids and procedures.

The Health Ministry, through the Department of Health and Social Services, has the responsibility for the overall efficiency and effectiveness of the provincial health system. Specifically, the Department is responsible for:

- setting overall directions and priorities;
- developing policies and strategies, legislation, provincial standards and measures;
- monitoring provincial health status;
- monitoring and ensuring that the five Regional Health Authorities comply with Regulations and standards;
- evaluating the performance of the health system;
- allocating funds to the five Regional Health Authorities;
- improving the quality and management of a comprehensive province-wide health information system;
- ensuring access to high-quality health services;
- addressing emerging health issues and examining new technology before implementation; and
- directly administering certain services and programs.

The five Regional Health Authorities are responsible for service delivery as allowed under the *Health and Community Services Act* (1993). The Authorities operate hospitals, health centres, manors and mental health facilities, and hire physicians, nurses and other health-related workers. Their responsibilities include:

- assessing the health needs of residents in their regions;
- providing for the input and advice of their residents;
- allocating and managing resources, setting priorities, hiring staff and making the best use of available resources;

- ☐ consulting with other organizations involved in the health field;
- ☐ developing policies, standards and measures;
- ☐ planning and coordinating with the Department and other authorities the delivery of the full range of health services;
- ☐ promoting health and wellness in their communities;
- ☐ making information available to residents on choices about health and health services;
- ☐ ensuring reasonable access to health services; and
- ☐ monitoring, evaluating and reporting on performance to residents and to the Ministry.

In December, 2001, Prince Edward Island's five health regions were awarded accredited status by the Canadian Council on Health Services Accreditation. The results of the accreditation process were announced following a comprehensive self-assessment process and surveys conducted in June, 2001, by a team of eleven physicians and senior health administrators from across the country.

1.2 Reporting Relationship

An annual report is submitted by the Department of Health and Social Services to the Minister responsible and is tabled by the Minister in the Legislative Assembly. The Annual Report provides information on the operating principles of the Department and its legislative responsibilities, as well as an overview and description of the operations of the departmental divisions, and statistical highlights for the year.

Each of the five Regional Health Authorities are required by statute to submit an annual report to the Minister of Health and Social Services. The Minister has the authority to request other information as deemed necessary on the operations of the Regional Health Authorities and their delivery of health services in their areas of jurisdiction. Regional Health Authorities are required to hold annual public meetings at which information about their operations and the provision of health services is presented.

1.3 Audit of Accounts

The provincial auditor general conducts annual audits of the Public Accounts of the Province of Prince Edward Island. The Public Accounts of the Province include the financial activities, revenues and expenditures of the Department of Health and Social Services.

Each Regional Health Authority has the responsibility to engage its own public accounting firm to conduct annual financial statement audits. The audited financial statements are provided to the Ministry and the Department of the Provincial Treasury. The reports are presented at public meetings held annually within each region. Audited statements are also presented to the Legislative Assembly and included within the published Public Accounts of the Province of Prince Edward Island.

The provincial auditor general, through the *Audit Act*, has the discretionary authority to conduct further audit reviews on a comprehensive or program-specific basis with respect to the operations of the Department of Health and Social Services, as well as each of the five Regional Health Authorities.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Insured hospital services are provided under the *Hospital and Diagnostic Services Insurance Act* (1988). The accompanying Regulations (1996) define the insured in- and out-patient hospital services available at no charge to a person who is eligible. Insured hospital services include:

- ☐ necessary nursing services;
- ☐ laboratory;
- ☐ radiological and other diagnostic procedures;
- ☐ accommodations and meals at a standard ward rate;
- ☐ formulary drugs, biologicals and related preparations prescribed by an attending physician and administered in hospital;
- ☐ operating room, case room and anaesthetic facilities;

- ☐ routine surgical supplies; and
- ☐ radiotherapy and physiotherapy services performed in hospital.

As of March, 2002, there were seven acute care facilities participating in the Province's insurance plan. In addition to 456 acute care beds, these facilities house 20 rehabilitative beds, 19 day-surgery beds, as defined under the *Hospitals Act* (1988) and seven insured chronic care beds. An additional facility, Prince Edward Home, has 50 insured chronic care beds. In addition, Prince Edward Island utilizes the equivalent of 28 acute care beds outside the Province and 5,142 days in lodges, hostels and alcohol/drug rehab facilities.

2.2 Insured Physician Services

The enabling legislation that provides for insured physician services is the *Health Services Payment Act* (1988). Amendments were passed in 1996. Changes were made to include the physician resource planning process.

Insured physician services are provided by medical practitioners licensed by the College of Physicians and Surgeons. The number of practitioners who billed the Insurance Plan as of March 31, 2002, was 217.

Under section 10 of the *Health Services Payment Act*, a physician or practitioner who is not a participant in the Insurance Plan is not eligible to bill the Plan for services rendered. When a non-participating physician provides a medically required service, section 10(2) requires that physicians advise patients that they are not participating physicians or practitioners and provide the patient with sufficient information to enable recovery of the cost of services from the Minister of Health.

Under section 10.1 of the *Health Services Payment Act*, a participating physician or practitioner may determine, subject to and in accordance with the Regulations and in respect of a particular patient or a particular basic health service, to collect fees outside of the Plan, or selectively opt out of the Plan. Before the service is rendered, patients must be informed that they will be billed directly for the service. Where practitioners have made that determination, they are required to inform the Minister thereof and the total charge is made to the patient for the service rendered.

As of March 31, 2002, no physicians had opted out of the Health Care Insurance Plan.

Any basic health services rendered by physicians that are medically required are covered by the Health Care Insurance Plan. These include:

- ☐ most physicians' services in the office, at the hospital or in the patient's home;
- ☐ medically necessary surgical services, including the services of anaesthetists and surgical assistants where necessary;
- ☐ obstetrical services, including pre- and post-natal care, newborn care or any complications of pregnancy such as miscarriage or Caesarean section;
- ☐ certain oral surgery procedures performed by an oral surgeon when it is medically required that they be performed in a hospital;
- ☐ sterilization procedures, both female and male;
- ☐ treatment of fractures and dislocations; and
- ☐ certain insured specialist services, when properly referred by an attending physician.

No services were added to the list of insured physician services in 2001-2002.

The process to add a physician service to the list of insured services involves negotiation between the Department of Health and Social Services and the medical society of the Province.

2.3 Insured Surgical-Dental Services

Dental services are not insured in the Plan. Only oral maxillofacial surgeons are paid through the Plan. There are currently two surgeons in that category. Surgical-dental procedures included as basic health services in the Tariff of Fees are covered only when the patient's medical condition requires that they be done in hospital as confirmed by the attending physician.

The addition of a surgical-dental service is conducted through negotiations with the Dental Association and the Department of Health and Social Services.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Provincial hospital services not covered by the Hospital Services Plan include:

- services that persons are eligible for under other provincial or federal legislation;
- mileage or travel, unless approved by the Department;
- advice or prescriptions by telephone, except anticoagulant therapy supervision;
- examinations required in connection with employment, insurance, education, etc.;
- group examinations, immunizations or inoculations, unless prior approval is received from the Department;
- preparation of records, reports, certificates or communications, except a certificate of committal to a psychiatric, drug or alcoholism facility;
- testimony in court;
- surgery for cosmetic purposes unless medically required;
- dental services other than those procedures included as basic health services;
- dressings, drugs, vaccines, biologicals and related materials;
- eyeglasses and special appliances;
- physiotherapy, chiropractic, podiatry, optometry, chiropody, osteopathy, psychology, naturopathy, audiology, acupuncture and similar treatments;
- reversal of sterilization procedures;
- *in vitro* fertilization;
- services performed by another person when the supervising physician is not present or not available;
- services rendered by a physician to members of the physician's own household, unless approval is obtained from the Department; and
- any other services that the Department may, upon the recommendation of the Medical Advisory Committee, declare non-insured.

Provincial hospital services not covered by the Hospital Services Plan include private or special duty nursing at the patient's or family's request; preferred accommodation at the patient's request; hospital services rendered in connection with surgery purely for cosmetic reasons; personal conveniences, such as telephones and televisions; drugs, biologicals, and prosthetic and orthotic appliances for use after discharge from hospital; and dental extractions, except in cases where the patient must be admitted to hospital for medical reasons with prior approval of the Department of Health and Social Services.

The process to de-insure services by the Health Care Insurance Plan is done in collaboration with the Medical Society and Department of Health and Social Services.

3.0 Universality

3.1 Eligibility

The *Health Services Payment Act* and Regulations section 3 define eligibility to the health care insurance plans. The plans are designed to provide coverage for eligible Prince Edward Island residents. A resident is anyone legally entitled to remain in Canada and who makes his or her home and is ordinarily present on an annual basis for at least six months plus a day in Prince Edward Island.

All new residents must register with the Department in order to become eligible. Persons who establish permanent residence in Prince Edward Island from elsewhere in Canada will become eligible for insured hospital and medical services on the first day of the third month following the month of arrival.

Residents who are ineligible for coverage under the health care insurance plan in Prince Edward Island are members of the Canadian Armed Forces (CAF), Royal Canadian Mounted Police (RCMP), inmates of federal penitentiaries, and those eligible for certain services under other government programs, such as Workers' Compensation or the Department of Veterans Affairs' programs.

Ineligible residents may become eligible in the following cases: members of the CAF, RCMP, and penitentiary prisoners on discharge, release, or release following the termination of rehabilitation leave. Where such is granted by the CAF, the province where incarcerated or stationed at time of release or discharge, or the province where resident on the completion of rehabilitation leave as may be appropriate, will provide initial coverage for the customary waiting period of up to three months. Parolees from penitentiaries will be treated in the same manner as discharged parolees.

Foreign students, tourists, transients, or visitors to Prince Edward Island do not qualify as residents of the Province and are therefore not eligible for hospital and medical insurance benefits.

3.2 Registration Requirements

New or returning residents must apply for health coverage by completing a registration application from the Department. The application is reviewed to ensure that all necessary information is provided. A health card is issued and sent to the resident within two weeks. Renewal of coverage takes place every five years and residents are notified by mail six weeks prior to renewal.

The number of residents registered for the health care insurance plan in Prince Edward Island as of March 31, 2002 was 140,001.

3.3 Other Categories of Individual

Foreign students, temporary workers, refugees and Minister's Permit holders are not eligible for health and medical coverage. Kosovar refugees are an exception to this category and are eligible for both health and medical coverage in Prince Edward Island. There were 99 Kosovar Refugees registered for Medicare as of March 31, 2002.

4.0 Portability

4.1 Minimum Waiting Period

Insured persons who move to Prince Edward Island are eligible for health insurance on the first day of the third month following the month of arrival in the Province.

4.2 Coverage During Temporary Absences in Canada

Persons absent each year for winter vacations and similar situations involving regular absences must reside in Prince Edward Island for at least six months plus a day each year in order to be eligible for sudden illness and emergency services while absent from the Province, as allowed under section 5.(1)(e) of the *Health Services Payment Act*.

The term "temporarily absent" is defined as a period of absence from the Province for up to 182 days in a 12 month period, where the absence is for the purpose of a vacation, a visit or a business engagement. Persons leaving the Province under the above circumstances must notify the Registration Department prior to leaving.

Prince Edward Island participates in the Hospital Reciprocal Billing Agreement and the Medical Reciprocal Billing Agreement.

The payment rate is $576 per day for hospital stays. The standard inter-provincial out-patient rate is $110. The methodology used to derive these rates is as if the patient had the services provided on Prince Edward Island.

4.3 Coverage During Temporary Absences Outside Canada

The *Health Services Payment Act* is the enabling legislation that defines portability of health insurance during temporary absences outside Canada, as allowed under section 5.(1)(e) of the *Health Services Payment Act*.

Insured residents may be temporarily out of the country for a 12 month period one time only. Students attending a recognized learning institution in another country must provide proof of enrolment from the educational institution on an annual basis. Students must notify the Registration Department upon returning from outside the country.

For Prince Edward Island residents leaving the country for work purposes for longer than one year, coverage ends the day the person leaves.

For Island residents travelling outside Canada, coverage for emergency or sudden illness will be provided at Prince Edward Island rates only, in Canadian currency. Residents are responsible for paying the difference between the full amount charged and the amount paid by the Department.

The amount paid for insured emergency services outside Canada in 2001-2002 was $136,829.

4.4 Prior Approval Requirement

Prior approval is required from the Department before receiving non-emergency out-of-province medical or hospital services. Prince Edward Island residents seeking such required services may apply for prior approval through a PEI physician. Full coverage may be provided for (Prince Edward Island-insured) non-emergency or elective services, provided the physician completes an application to the Department. Prior approval is required from the Medical Director of the Department of Health and Social Services to receive out-of-country hospital or medical services not available in Canada.

5.0 Accessibility

5.1 Access to Insured Health Services

Both of Prince Edward Island's hospital and medical services insurance plans provide services on uniform terms and conditions on a basis that does not impede or preclude reasonable access to those services by insured persons.

5.2 Access to Insured Hospital Services

The seven acute care facilities in Prince Edward Island have a total of 476 (456 acute care and 20 rehabilitative) approved beds. There are also 23 acute care beds providing insured hospital services in a psychiatric facility. There are no admission data for these beds. During the 2001-2002 fiscal year, the total number of in-patient admissions was 16,941. The number of in-patient days in Prince Edward Island hospital acute care beds totalled 134,846 days (excluding newborns), with an average stay of 8.1 days. There are no data available on admissions, length of stay, and in-patient days for chronic care beds.

Linear Accelerator

In April, 2000, the Government announced plans to expand the range of services that can be provided at the PEI Cancer Treatment Centre, through the addition of linear accelerator services. An impact analysis and functional plan for expanded cancer treatment services is now in the process of being completed. Expanded cancer treatment services are expected to be operational in late 2002.

Magnetic Resonance Imaging (MRI)

In April, 2000, the Government announced that diagnostic imaging services for Islanders will be expanded through the purchase of a Magnetic Resonance Imaging (MRI) unit for the Queen Elizabeth Hospital. A committee has been established to oversee the planning phase for the establishment of the MRI service, which is expected to be operational in late 2002. An impact analysis has been completed and the functional plan is in the process of being finalized.

Ambulance Services

Amendments to the *Public Health Act* related to emergency medical services and accompanying Regulations were approved for proclamation January 1, 2001. This Act provides for enhancements in administration and delivery of emergency medical services.

In April, 2000, the Government announced the Out of Province Medical Transport Support Program to cover a portion of the cost of out-of-province ground ambulance transportation. This program reduces the user fee for eligible Island residents who need specialized medical care outside the Province.

Accessibility – New Initiatives

The Nurse Recruitment Strategy, announced in the 2000 PEI Budget, is in its third year of operation. All strategies have been implemented in PEI. While the Nurse Recruitment Strategy addresses all sectors of health care, priority is given to the institutional sector, which covers acute and long-term care services. The Department is currently developing a framework for the formal evaluation of the strategies.

5.3 Access to Insured Physician and Dental-Surgical Services

Physician services are accessible throughout the Province except for specialties where there are vacancies. Recruitment processes were undertaken for family physicians, anaesthetists, radiologists, pathologists, ophthalmologists, radiation oncologists, psychiatrists, and one obstetrician.

5.4 Physician Compensation

A collective bargaining process is used to negotiate physician compensation. Bargaining teams are appointed by both physicians and government to represent their interests in the process. A new three-year agreement was negotiated and is in effect until March 31, 2004.

The legislation governing payments to physicians and dentists for insured services is the *Health Services Payment Act*.

Most physicians work on a fee-for-service basis. However, alternate payment plans have been developed and some physicians receive salary, contract and sessional payments.

5.5 Payments to Hospitals

Regional Health Authorities are responsible for the delivery of hospital services in the Province under the *Health and Community Services Act*. The financial (budgetary) requirements are established annually through consultation with the Department of Health and Social Services and are subject to approval by the Legislative Assembly through the annual budget process.

Payments (advances) to the Regional Health Authorities for hospital services are approved for disbursement by the Department in line with cash requirements and are subject to approved budget levels.

The usual funding method includes the use of a global budget adjusted annually to take into consideration increased costs related to such items as labour agreements, drugs, medical supplies and facility operations.

6.0 Recognition Given to Federal Transfers

The Government of Prince Edward Island acknowledged the federal contributions provided through the Canada Health and Social Transfers in its 2001-2002 Annual Budget and related budget documents, and its 2001-2002 Public Accounts, which were tabled in the Legislative Assembly and are publicly available to Prince Edward Island residents.

7.0 Extended Health Care Services

Extended health care services are not an insured service, with the exception of the insured chronic care beds noted in section 2.1. Extended care services are provided through the five Regional Health Authorities of the Health and Social Services system. Nursing home services are available upon approval from regional admission and placement committees for placement into government manors and licensed private nursing homes. The standardized Services Assessment Screening Tool is used for determining service needs of residents for all admissions to nursing homes. There are 18 government and private nursing home facilities in the Province, with a total of 953 beds, including respite beds. The Province subsidizes 71 percent of residents in nursing homes as per the Welfare Assistance Act Regulations, Part 2. The federal government subsidizes approximately eight percent of residents. The remaining 21 percent of residents pay their own way. Nursing homes in Prince Edward Island provide Levels 4 and 5 care.

In addition to nursing home facilities, there are 35 licensed community care facilities in Prince Edward Island. As of March 31, 2002, the total number of licensed community care facility beds was 923. The 35 percent of residents who are subsidized require a financial assessment as per the *Welfare Assistance Act*, Part 1.

The remaining 65 percent pay their own way. Community Care facilities provide Levels 1 to 3 care.

Home Care and Support services, also uninsured, are another component of extended care. Support services include home care nursing, visiting homemakers, community support, adult protection, and occupational and physiotherapy supports. The Senior's Assessment Tool is used to determine the nature and type of service needed. Professional services in home care are currently provided at no cost to the client but are subject to a budget cap. Visiting homemaker services are subject to a sliding fee scale based on an individual's income assessment. The demand for home care continues to increase in PEI.

Nova Scotia

Introduction

The management of day-to-day health services delivery in Nova Scotia is the responsibility of the Province's nine District Health Authorities (DHAs). These DHAs were created under the *Health Authorities Act*, which came into effect on January 1, 2001. The passage of this Act brought Nova Scotia closer to its goal of developing an affordable, high quality, sustainable health care system.

Under the *Health Authorities Act*, the DHAs are required to provide the Minister of Health with monthly and quarterly financial statements and audited year-end financial statements. They are also required to submit annual reports, which provide updates on the implementation of DHA business plans. These provisions ensure greater financial accountability. The sections of the *Health Authorities Act* related to financial reporting and business planning came into effect on April 1, 2001.

Pursuant to the *Provincial Financial Act* and government policies and guidelines, the Department of Health is required to release annual accountability reports outlining outcomes against its business plan for that fiscal year. The *Annual Accountability Report for the Year 2000-2001* was the first of its kind. The 2001-2002 accountability report will be available late 2002.

The Province also released its report, *Performance Evaluation of Nova Scotia Emergency Health Services*, during the 2001-2002 fiscal year. This report evaluates the changes made to the Province's emergency health services system brought on by restructuring that began in 1995. It concludes that the amalgamation of multiple ambulance providers has resulted in significant improvements. Among these improvements are an increase in consistency and equity, and an overall reduction in ambulance response times.

Nova Scotia continues to be committed to the delivery of medically necessary services that are consistent with the principles of the *Canada Health Act*.

Additional information related to health care in Nova Scotia may be obtained from the Department of Health website at:

www.gov.ns.ca/health

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

Two plans cover insured health services in Nova Scotia: the Hospital Insurance Plan (HSI) and the Medical Services Insurance Plan (MSI). The Department of Health administers the HSI Plan, which operates under the *Health Services and Insurance Act*, Chapter 197, Revised Statutes of Nova Scotia, 1989: sections 3(1), 5, 6, 10, 15, 16, 17(1), 18, 35, passed by the Legislature in 1958.

The MSI is administered and operated on a non-profit basis by an authority consisting of the Department of Health and Maritime Medical Care Incorporated (now known as Atlantic Blue Cross Care), under the legislation previously mentioned (sections 8, 13, 17(2), 23, 27, 28, 29, 30, 31, 32, 35).

Section 3 of the *Health Services and Insurance Act* states that subject to this Act and the Regulations, all residents of the Province are entitled to receive insured hospital services from hospitals on uniform terms and conditions, and that all residents of the Province are insured upon uniform terms and conditions in respect of the payment of insured professional services to the extent of the established tariff. Section 8 of the Act gives the Minister of Health, with approval of the Governor in Council, the power to, from time to time, enter into agreements and vary, amend, or terminate the same with such person or persons as the Minister deems necessary to establish, implement and carry out the MSI Plan.

Maritime Medical Care Incorporated (now known as Atlantic Blue Cross Care), by virtue of the 1992 Memorandum of Agreement, is mandated to:

- ☐ determine the eligibility of providers participating in the Plan;
- ☐ plan and conduct information and education programs necessary to ensure that all persons and providers are informed of their entitlements and responsibilities under the Plan;
- ☐ make payments under the Plan for any claim or class of claims for insured health services for which the Province is liable; and
- ☐ develop an audit and assessment system of claims and payments, to maintain a continuous audit process and to establish any other administrative structures required to fulfill its mandate.

1.2 Reporting Relationship

MMC is required to submit to the Province, no later than the 20th day of each month, monthly expenditure reports, including such detail as determined by the Province. Within 30 days of the end of the fiscal quarter, MMC is required to provide a report that includes expenditures to the end of the quarter and a forecast of expenditures to the end of the year. MMC is required to provide minutes and any information necessary to keep the Province informed of all meetings, conferences, etc., that are charged to the MSI Plan. Reports prepared by MMC are forwarded to the respective Insured Program areas of the Department of Health for review and follow-up.

Section 17(1)(i) of the *Health Services and Insurance Act*, and sections 11(1) and 12(1) of the Hospital Insurance Regulations, which relate to this Act, set out the terms for reporting by hospitals and hospital boards to the Minister of Health, their annual budget estimates and their monthly reports of actual revenues and expenditures.

1.3 Audit of Accounts

The Auditor General's office audits all expenditures of the Department of Health, including Pharmacare, the provincial drug program. The Department of Health's internal auditors perform a financial audit of the administration contract at Maritime Medical Care. MMC also has an external audit conducted, which includes the administrative contract. No official audit is performed on Medicare payments, however, this is being recommended by the Auditor General's office.

Under Section 34(5) of the *Health Authorities Act*, every hospital board is required to submit to the Minister of Health by July 1 each year, an audited financial statement for the preceding fiscal year.

The Report of the Auditor General of Nova Scotia, tabled on January 7, 2002, contained three audits that are relevant to the *Canada Health Act*:

- ☐ a government-wide audit of the financial planning and budgeting process for 2001-2002;
- ☐ an audit of the Capital District Health Authority; and
- ☐ an audit of the Province's acquisition of the Dartmouth Corrections and Forensic facility.

1.4 Designated Agency

MMC administers and has the authority to receive monies to pay physician accounts under a Memorandum of Agreement with the Department of Health. MMC receives written authorization from the Department on the payees to which it may make payments. The rates of pay and specific amounts are dependent on the physician contract negotiated between the Medical Society of Nova Scotia and the Department of Health.

There is no legislation governing the role of MMC. MMC abides by the terms and conditions of the 1992 contract and its payment mechanism. Under this contract, MMC is required to submit to the Province:

- ☐ annual audited financial statements;
- ☐ detailed line-by-line FTE counts on budget requests in which the Department actually approves staffing levels;
- ☐ line-by-line budgets showing salary, benefits, travel, postage, etc.; and
- ☐ a copy of the Annual Report.

All MMC system development for MSI and Pharmacare is controlled through a joint committee. All MSI and Pharmacare transactions are subject to a review by the Office of the Auditor General.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Nine District Health Authorities and the IWK Health Centre (Women and Children's Tertiary Care Hospital) deliver insured hospital services to both in- and out-patients in Nova Scotia in a total of 35 facilities[1].

Accreditation is not mandatory but all facilities are accredited at a facility or regional level. The enabling legislation that provides for insured hospital services in Nova Scotia is the *Health Services and Insurance Act*, Chapter 197, Revised Statutes of Nova Scotia, 1989: sections 3(1), 5, 6, 10, 15, 16, 17(1), 18, and 35, passed by the Legislature in 1958. Hospital Insurance Regulations were made pursuant to the *Health Services and Insurance Act*.

In-patient services include:

- accommodation and meals at the standard ward level;
- necessary nursing services;
- laboratory, radiological and other diagnostic procedures;
- drugs, biologicals and related preparations, when administered in a hospital;
- routine surgical supplies;
- use of operating room, case room and anaesthetic facilities;
- use of radiotherapy and physiotherapy services, where available; and
- blood or therapeutic blood fractions.

Out-patient services include:

- laboratory and radiological examinations;
- diagnostic procedures involving the use of radio-pharmaceuticals;
- electroencephalographic examinations;
- use of occupational and physiotherapy facilities, where available;
- necessary nursing services;
- drugs, biologicals and related preparations;
- blood or therapeutic blood fractions;
- hospital services in connection with most minor medical and surgical procedures;
- day-patient diabetic care;
- services other than medical services provided by and within the Nova Scotia Hearing and Speech Clinic;
- ultrasonic diagnostic procedures;
- home parenterel nutrition; and
- haemodialysis and peritoneal dialysis.

2.2 Insured Physician Services

The legislation covering the provision of insured physician services in Nova Scotia is the *Health Services and Insurance Act*, sections 3(2), 5, 8, 13, 13A, 17(2), 22, 27-31, 35, and the Medical Services Insurance Regulations.

Under the *Health Services and Insurance Act* a general practitioner means a person who engages in the general practice of medicine, or a physician who is not a specialist within the meaning of the clause, and a specialist who is a physician and is recognized as a specialist by the appropriate licensing body of the jurisdiction in which he or she practises. Physicians (general practitioner or specialist) must be licensed by the College of Physicians and Surgeons in Nova Scotia in order to be eligible to bill the MSI system. Dentists receiving payment under the MSI Plan must be registered with the Provincial Dental Board and be recognized as dentists. In 2001-2002, 2,003 physicians and 35 dentists were paid through the MSI Plan.

Physicians retain the ability to opt into or out of the MSI Plan. In order to opt out, a physician notifies MSI, relinquishing their billing number. Patients who pay the physician directly due to opting out are reimbursed for these services by MSI. As of March 31, 2002, no physicians had opted out.

Insured services are those medically necessary to diagnose, treat, rehabilitate or otherwise alter a disease pattern. There are no limitations on medically necessary insured services.

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[1] As per the the definitions set out in the *Canada Health Act Annual Report 2001-2002 User's Guide for Submissions to Health Canada*. This number has not changed from the 2000-2001 fiscal year, but was erroneously reported as 36 in last year's CHA submission. The number of facilities reported in other documents may differ from 35 as a result of the use of differing definitions.

No new large-scale services were added to the list of insured physician services in 2001-2002. On a quarterly ongoing basis, new specific fee codes are approved that represent either enhancements, new technologies or new ways of delivering a service.

The addition of new fee codes to the list of insured physician services is accomplished through a committee structure. Physicians wishing to have a new fee code recognized or established must first present their cases to the Medical Society of Nova Scotia, which puts a suggested value on the proposed new fee.

The proposal is then passed to the Joint Fee and Tariff Committee for review and approval. The Joint Committee is comprised of equal representation from the Medical Society and Department of Health. When approved by the Joint Fee Schedule Committee, the approved proposed new fee is forwarded to the Department of Health for final approval and MMC is directed to add the new fee to the schedule of insured services payable by the MSI Plan.

2.3 Insured Surgical-Dental Services

Under the *Health Services and Insurance Act* a dentist is defined as a person lawfully entitled to practise dentistry in a place in which such practice is carried on by that person.

To be permitted to provide insured surgical-dental services under the *Health Services and Insurance Act*, dentists must be registered members of the Nova Scotia Dental Association and must also be certified competent in the practice of dental surgery. The *Health Services and Insurance Act* is so written that a dentist may choose not to participate in the MSI Plan. To participate, a dentist must register with MSI. A participating dentist who wishes to reverse election to participate must advise MSI in writing and is then no longer eligible to submit claims to MSI. As of March 31, 2001, no dentists had opted out. In 2001-2002, 35 dentists were paid through the MSI Plan for providing insured surgical-dental services.

Insured surgical-dental services must be provided in a health care facility. Insured services are listed in the Dental Surgical Program Fee Schedule. Services under this program are insured when the conditions of the patient are such that it is medically necessary for the procedure to be done in a hospital and the procedure is of surgical nature. Generally included as insured surgical-dental services are orthognathic surgery, surgical removal of impacted teeth and oral and maxillary facial surgery. Additions to the list of surgical-dental services that are insured are accomplished by first approaching the Dental Association of Nova Scotia and having them put forward a proposal to the Department of Health for the addition of a new procedure. The Department of Health, in consultation with specific experts in the field, renders the decision as to whether or not the new procedure becomes an insured service.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Uninsured hospital services include:

- ☐ preferred accommodation at the patient's request;
- ☐ telephones;
- ☐ televisions;
- ☐ drugs and biologicals ordered after discharge from hospital;
- ☐ cosmetic surgery;
- ☐ reversal of sterilization procedures;
- ☐ surgery for sex reassignment;
- ☐ *in-vitro* fertilization;
- ☐ procedures performed as part of clinical research trials;
- ☐ services such as gastric bypass for morbid obesity, breast reduction/augmentation, and newborn circumcision, except because of medical necessity; and
- ☐ services not deemed medically necessary that are required by third parties, such as insurance companies.

Uninsured physician services include:

- ☐ those a person is eligible for under the *Workers' Compensation Act* or under any other federal or provincial legislation;

- ☐ mileage, travelling or detention time;
- ☐ telephone advice or telephone renewal of prescriptions;
- ☐ examinations required by third parties;
- ☐ group immunizations or inoculations unless approved by the Department;
- ☐ preparation of certificates or reports;
- ☐ testimony in court;
- ☐ services in connection with an electrocardiogram, electromyogram or electroencephalogram, unless the physician is a specialist in the appropriate specialty;
- ☐ cosmetic surgery;
- ☐ acupuncture;
- ☐ reversal of sterilization; and
- ☐ *in-vitro* fertilization.

All residents of the Province are entitled to services covered under the *Health Services and Insurance Act*. If there is the ability for a patient to purchase enhanced goods and services, such as the foldable interocular lens or a fibreglass cast, patients are required to be fully informed about the cost and are not to be denied service based on their inability to pay. The Province provides alternatives to any of the enhanced goods and services.

The Department of Health also carefully reviews all patient complaints or public concerns that may indicate that the general principles of insured services are not being followed.

The de-insurance of insured physician services is accomplished through a negotiation process between the Medical Society of Nova Scotia and the Department of Health representatives, who jointly evaluate a procedure or process to determine its medical necessity. If a process or procedure is deemed not to be medically necessary, it is removed from the physician fee schedule and will no longer be reimbursed to physicians as an insured service. Once a service has been de-insured, all procedures and testing relating to the provision of that service also become de-insured. The same process applies to dental and hospital services. The last time there was any significant amount of de-insurance of services was in 1997.

3.0 Universality

3.1 Eligibility

Eligibility for insured health care services in Nova Scotia is outlined under section 2 of the Hospital Insurance Plan Regulations pursuant to section 17 of the *Health Insurance Act*. All residents of Nova Scotia are eligible. A resident is defined as anyone who is legally entitled to stay in Canada and who makes his or her home and is ordinarily present in Nova Scotia.

Persons moving to Nova Scotia from another Canadian province will normally be eligible for MSI on the first day of the third month following the month of their arrival as permanent residents. Persons moving permanently to Nova Scotia from another country are eligible on the date of their arrival in the Province, provided they are Canadian citizens.

Members of the Royal Canadian Mounted Police, members of the Canadian Armed Forces, federal inmates and members of the North Atlantic Treaty Organization are ineligible for MSI coverage. When their status changes, they become eligible on the first day of the third month following the month in which their eligibility status changed.

3.2 Registration Requirements

To obtain a health card in Nova Scotia, residents must register with MSI. Once eligibility has been determined, an application form is generated. The applicant (and spouse if applicable) must sign the form before it can be processed. The applicant must indicate on the application the name and mailing address of a witness. The witness must be a Nova Scotia resident who can confirm the information on the application. The applicant must include proof of Canadian citizenship or provide a copy of an acceptable Immigration Document.

When the application has been approved, health cards will be issued to each family member listed. Each health card number is unique and is issued for the lifetime of the applicant. The health card number also acts as the primary health record identifier for all health service encounters in Nova Scotia for the life of the recipient. Proof of eligibility for insured services is required before residents are eligible to receive insured services.

Renewal notices are sent to most cardholders three months before the expiry date of the current Health Card. Upon return of a signed renewal notice, MSI will issue a new health card.

There is no legislation in Nova Scotia forcing residents of the Province to apply for MSI. There may be residents of Nova Scotia who, therefore, are not members of the health insurance plan.

In 2001-2002, there were 948,369 residents registered with the health insurance plan.

3.3 Other Categories of Individual

The following persons may also be eligible for insured health care services in Nova Scotia, once they meet the specific eligibility criteria for their situations:

Immigrants: Persons moving to Nova Scotia from another country to live permanently, are eligible for health care on the date of arrival. They must be in possession of a landed immigrant document. These individuals, formerly called "landed immigrants," are now referred to as "Permanent Residents."

Non-Canadians who are married to a Canadian Citizen or a "Permanent Resident," and Convention Refugees who have applied in Canada for permanent residence status, are eligible for insured services as of the date of application for Permanent Resident status. Applicants must possess a letter from Citizenship and Immigration Canada verifying their status. A Convention Refugee is a person designated by the Immigration Refugee Board to have been found to fear persecution in his or her country of origin because of race, religion, nationality, membership in a social group, or political opinion.

Persons from outside Canada, who have applied for Permanent Resident status, cannot register until they become Permanent Residents. Coverage will be retroactive to their date of arrival in Nova Scotia.

In 2001-2002, there were 16,986 permanent residents registered with the health care plan.

Employment Authorizations: Persons moving to Nova Scotia from another country, who possess an Employment Authorization, are eligible to apply for MSI on the first day of the seventh month following the date of arrival as a worker, provided they have not been absent from Nova Scotia for 31 consecutive days, except in the course of employment. MSI coverage is extended for a maximum of 12 months at a time and only for services received within Nova Scotia, which is indicated on their Health Cards. Coverage is retroactive to the day of arrival. Each year a copy of their renewed immigration document must be presented and a declaration signed. Dependants of such persons will be granted coverage on the same basis once the worker has gained entitlement.

In 2001-2002, there were 302 individuals with Employment Authorizations covered under the health care insurance plan.

Students Authorizations: Persons moving to Nova Scotia from another country, who possess a Student Authorization will be eligible for MSI on the first day of the thirteenth month following the month of their arrival, provided they have not been absent from Nova Scotia for more than 31 consecutive days. MSI coverage is extended for a maximum of 12 months at a time and only for services received within Nova Scotia. Each year, a copy of their renewed immigration document must be presented and a declaration signed. Dependants of such persons will be granted coverage on the same basis, once the student has gained entitlement.

In 2001-2002, there were 378 individuals with Student Authorizations covered under the health care insurance plan.

Refugees: Refugees are eligible for MSI if they are in possession of either an employment or student authorization, or if they have made application for Permanent Resident status. They are governed by the eligibility provisions for the type of immigration document that they possess.

4.0 Portability

4.1 Minimum Waiting Period

Persons moving to Nova Scotia from another Canadian province or territory will normally be eligible for MSI on the first day of the third month following the month of their arrival as Permanent Residents.

4.2 Coverage During Temporary Absences in Canada

The Agreement of Eligibility and Portability is followed in all matters pertaining to portability of insured services.

Generally, the Nova Scotia MSI Plan provides coverage for residents of Nova Scotia who move to other provinces or territories for a period of three months as per the Eligibility and Portability Agreement. Students who are temporarily absent from Nova Scotia and in full-time attendance at an educational institute, may remain eligible for MSI on a yearly basis. To qualify for MSI, the student must provide to MSI, a letter, obtained from the educational institute that verifies the student's attendance at the educational institute in each year for which MSI coverage is requested.

Workers who leave Nova Scotia to seek employment elsewhere will remain covered by MSI for up to 12 months, provided they do not establish residence in another province, territory, or country.

Services provided to Nova Scotia residents in other provinces or territories, are covered by reciprocal agreements. Nova Scotia participates in the Hospital Reciprocal Billing Agreement and the Medical Reciprocal Billing Agreement. In-patient hospital services are paid through the interprovincial reciprocal billing arrangement at the standard ward rate of the hospital providing the service. The total amounts paid by the Plan in 2001-2002, for in- and out-patient hospital services received in other provinces and territories were: $8,536,691 for out-of-province in-patient services, and $4,009,667 for out-of-province out-patient services. Nova Scotia pays the host province rates for insured services in all reciprocal-billing situations.

4.3 Coverage During Temporary Absences Outside Canada

Nova Scotia adheres to the Agreement on Eligibility and Portability for dealing with insured services for residents temporarily outside Canada. Provided a Nova Scotia resident meets eligibility requirements, out-of-country services will be paid, at a minimum, on the basis of the amount that would have been paid by Nova Scotia for similar services rendered in this province. Ordinarily, to be eligible for coverage, residents must not be outside of the country for more than six months. In order to be covered, procedures of a non-emergency basis must have prior approval before they will be covered by MSI.

Students who are temporarily absent from Nova Scotia and in full-time attendance at an educational institute outside Canada may remain eligible for MSI on a yearly basis. To qualify for MSI, the student must provide to MSI, a letter, obtained from the educational institute that verifies the student's attendance at the educational institute in each year for which MSI coverage is requested.

Workers who leave Nova Scotia to seek employment elsewhere remain covered by MSI for up to 12 months, provided they do not establish residence in another country.

Emergency out-of-country services are paid at a minimum on the basis of the amount that would have been paid by Nova Scotia for similar services rendered in this province. The total amount spent in 2001-2002 for insured in-patient emergency services provided outside of Canada was $1,000,023.

4.4 Prior Approval Requirement

Prior approval must be obtained for elective services in another province or outside the country. Application for prior approval is made to the Medical Director of the MSI Plan by a physician in Nova Scotia on behalf of an insured resident. The medical consultant reviews the terms and conditions and determines whether or not the service is available in the Province, or if it can be provided in another province or only out-of-country. The decision of the Medical Consultant is relayed to the patient's physician. The patient is then covered under the Reciprocal

Billing Agreement for elective services in another province or territory. If approval is given to obtain service outside the country, the full cost of that service will be covered under MSI.

5.0 Accessibility

5.1 Access to Insured Health Services

Insured services are provided to Nova Scotia residents on uniform terms and conditions.

There are no user charges or extra charges under either plan.

Nova Scotia continually reviews access situations across Canada to ensure that it is not falling behind. In areas where improvement is deemed necessary, depending on the Province's financial situation, extra funding is generally allocated to that area. Additional funding was devoted to cardiac catheterization and cardiac surgery on this basis during the 2001-2002 fiscal year. The Province also commissioned a review and subsequent report with recommendations for osteoporosis treatment including improved access to bone densitometry services. During the 2002-2003 fiscal year, approval was given for the purchase of an MRI for Cape Breton to increase access and reduce wait times.

5.2 Access to Insured Hospital Services

The Government of Nova Scotia continues to place emphasis on the provision of sustainable, quality health care services to its citizens.

There were a total of 2,982 hospital beds in Nova Scotia in the most recent count of the 2001-2002 fiscal year.

Table 1 provides a breakdown of key health professions that are licensed to practise in Nova Scotia. Not all of these health professionals were actively involved in delivering insured health services.

Table 1: Health Personnel in Nova Scotia (2001)

Health Occupation	Registered/ Licensed to Practise[2]
Physicians	2,003
Dentists	450[3]
Registered Nurses	9,272
Licensed Practical Nurses	3,369
Medical Radiation Technologists	483
Respiratory Therapists	186
Pharmacists	949
Occupational Therapists	233
Speech-Language Pathologists	155
Chiropractors	73
Opticians	173
Optometrists	76
Denturists	61
Dietitians	402
Psychologists	371

In Nova Scotia in 2001-2002, Telehealth was also used to provide the services listed in Table 2.

Table 2: Telehealth Services in Nova Scotia (2001-2002)

Type of Telehealth Event	Number of "Events"
Tele-radiology Cases	12,993
Education Sessions	1,865
Clinical Consultations	1,312
Administrative Meetings	701
Clinical Case Conferences	187

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[2] Not all professionals licensed to practise actually work.

[3] A limited number of licensed dentists are approved for insured dental services.

5.3 Access to Insured Physician and Dental-Surgical Services

In 2001-2002, there were 2,003 physicians and 35 dentists actively providing insured services under the *Canada Health Act* or provincial legislation. Innovative funding solutions such as block funding and personal services contracts have enhanced recruitment.

The Province has increased general practice medical training, conducts ongoing recruitment activities and has provided funding to create a re-entry program for general practitioners wishing to enter specialty training after completing two years of general practice service in the Province.

5.4 Physician Compensation

The *Health Services and Insurance Act* RS Chapter 197 governs payment to physicians and dentists for insured services. Physician payments are made in accordance with a negotiated agreement between the Medical Society of Nova Scotia and the Nova Scotia Department of Health. The Medical Society of Nova Scotia is recognized as the sole bargaining agent in support of physicians in the Province. When negotiations take place, representatives from the Medical Society and the Department of Health negotiate the total funding and other terms, and conditions and enhancements that the Medical Society may bring to the table in light of the fiscal restraints on the Province. Each negotiated agreement contains a provision for binding arbitration (Article 9), should there be an impasse in a dispute. The current master agreement negotiated April 1, 2001, and expiring March 31, 2004, contains an alternate dispute resolution mechanism.

The agreement lays out what the medical service unit value will be for physician services and addresses issues of stand-by or call-back compensation, members' benefit fund, Canadian Medical Protective Association funding and rural stabilization funding. Fee-for-service is still the most prevalent method of payment for physician services, followed by alternative funding arrangements. Other payment methods include hourly funding, and sessional funding.

In 2001-2002, payments for fee-for-service in Nova Scotia totalled $221,133,176. The Department paid an additional $5,078,794 for insured physician services provided to Nova Scotia residents outside the Province, but within Canada.

Payment rates for dental services in the Province are negotiated between the Department of Health and the Dental Association of Nova Scotia and follow a process similar to physician negotiations. Dentists are paid on a fee-for-service basis. The current agreement expires on March 31, 2004.

5.5 Payments to Hospitals

The Department of Health establishes budget targets for health care services. It does this by receiving business plans from the nine District Health Authorities (DHAs), the IWK Health Centre, and other non-DHA organizations. Approved provincial estimates form the basis on which payments are made to these organizations for service delivery.

The *Health Authorities Act* was given Royal Assent on June 8, 2000. The Act instituted the nine district health authorities that replaced the former regional health boards. This change came into effect in January, 2001, under the District Health Authorities General Regulations. The implementation of community health boards under the Community Health Boards' Member Selection Regulations was effective April, 2001. The DHAs are responsible (section 20 of the Act) for overseeing the delivery of health services in their districts and are fully accountable for explaining their decisions on the community health plans through their business plan submissions to the Department of Health.

Section 10 of the *Health Services and Insurance Act* and sections 9 through 13 of the Hospital Insurance Regulations define the terms for payments by the Minister of Health to hospitals for insured hospital services.

In 2001-2002, there were 2,982 hospital beds in Nova Scotia (3.1 beds per 1,000 population). Department of Health direct expenditures for insured hospital services' operating costs were increased to $926.8 million. Total separations from all hospitals decreased slightly to 200,395.

6.0 Recognition Given to Federal Transfers

In Nova Scotia the *Health Services and Insurance Act* RS Chapter 197 acknowledges the federal contribution in respect of the cost of insured hospital services and insured health services provided to provincial residents. The residents of Nova Scotia are aware, through press releases and media coverage of ongoing negotiations between the provinces and the federal government, that Canada Health and Social Transfer (CHST) funding partially assists in the provision of insured medical services in the Province.

The Government of Nova Scotia also recognized the federal contribution under the CHST in various published documents including the following documents released in 2001-2002:

- ☐ Public Accounts 2000-2001;
- ☐ Budget Estimates 2001-2002 and 2002-2003; and
- ☐ Department of Finance Year-End Forecast.

7.0 Extended Health Care Services

These following services are not insured under the *Canada Health Act*.

Nursing Homes

Nursing homes in Nova Scotia provide care primarily to seniors at Level I and Level II. Level I care deals with residents in homes requiring personal care and assistance with activities of daily living. Level II care involves Level I care plus specific nursing care. This level of care is increasing dramatically as the population ages. The aging-in-place phenomenon means those seniors who were Level I are rapidly moving into Level II.

Adult Residential Care Services

Adult residential care services in Nova Scotia continue to be under the jurisdiction of the Department of Community Services and are not considered to be insured services for the purposes of the *Canada Health Act*.

Home Care Services

Home Care Nova Scotia was introduced in 1995. This program assists seniors to remain in their own homes longer, thus delaying admission to a long-term care facility. Primarily, Home Care Nova Scotia provides personal care in clients' homes along with nursing care, if required. The two major components of the program are chronic and acute patient care. The chronic component makes up approximately 80 percent of home-care clients with the remaining 15 to 20 percent being acute home care, which allows for early discharge from hospital. Home Care Nova Scotia also provides a home oxygen program. This program is still developing, and other components will be added in the future, such as occupational therapy, physiotherapy, social work, palliative care, paediatrics, and others as deemed necessary.

The Nova Scotia Department of Health has recently implemented its Single Entry Access (SEA) process. SEA now helps Nova Scotians connect with home care, long-term care placement and adult protection services through a single toll-free telephone number.

8.0 Additional Materials Submitted to Health Canada

Changes to Acts, Regulations and legislation in 2001 and 2002:

- ☐ *Smoke-free Places Act*;
- ☐ *Atlantic Blue Cross Care Inc. Act*;
- ☐ *Licensed Practical Nurses Act*;
- ☐ *Registered Nurses Act*;
- ☐ *Optometry Act*;

- ☐ *District of Barrington Health Professionals Assistance Act;*
- ☐ *Healthcare Services Continuation (2001) Act;*
- ☐ *Pharmacy Act;*
- ☐ *Izaak Walton Killam - Grace Health Centre Act.*

Lists of Reports and Administrative documents that describe Nova Scotia's health care insurance plan, provides analysis or assessment of the health care system during the fiscal year 2001-2002, or were released during the 2001-2002, fiscal year:

- ☐ Department of Health 2001-2002 Business Plan;
- ☐ Report on Lead and Arsenic Testing in Sydney, N.S., November 2001;
- ☐ The Economic Impact of Smoke-Free Workplace Legislation: An Assessment for Nova Scotia, September 2001;
- ☐ Tobacco Strategy for Nova Scotia, 2001;
- ☐ Nova Scotia's Nursing Strategy, April 2000;
- ☐ Strengthening Primary Care in Nova Scotia Communities Initiative;
- ☐ Comprehensive Report on Injuries in Nova Scotia, May 2002;
- ☐ Managing Osteoporosis: A Nova Scotia Approach, June 2002;
- ☐ Medical Equipment List -- Allocation of Final $15 million in Federal Funding, June 2002;
- ☐ Performance Evaluation of Nova Scotia Emergency Health Services, November 2001;
- ☐ Submission to the Commission on the Future of Health Care in Canada (The Romanow Commission), April 2002;
- ☐ Province of Nova Scotia's Annual Accountability Report for the fiscal year 2000-01;
- ☐ Department of Health Annual Accountability Report, 2001-2002;
- ☐ Report of the Auditor General, 2001.

Reports giving recognition to federal contributions provided under the Canada Health and Social Transfer (CHST):

- ☐ Public Accounts, 2000-2001;
- ☐ Nova Scotia Budget, 2001-2002;
- ☐ Nova Scotia Budget, 2002-2003;
- ☐ Fiscal 2001-2002 Forecast Update;
- ☐ Fiscal 2002-2003 Forecast Update.

New Brunswick

Introduction

The Premier's Health Quality Council was established in January, 2000, to make recommendations to the government on renewing New Brunswick's health system. A discussion paper, released in the spring, 2001, aimed at forging a discussion with New Brunswickers on how to best achieve a community-based, individual-focused sustainable health system. The final report was presented to the Premier in January, 2002.

As a result, a new *Regional Health Authority Act* came into force in April, 2002. This established eight Regional Health Authorities (RHAs) with responsibility for providing for the delivery of and administering health services in specified geographic areas and, where authorized, in other areas of the Province. This Act specifically sets out the powers and duties of the Minister and the powers, duties and responsibilities of the Regional Health Authorities.

Each RHA includes a regional facility and a number of smaller facilities, all of which provide insured services to in- and out-patients. Each RHA has other health facilities or health centres, without designated beds, that provide a range of services to entitled persons. The population of New Brunswick is approximately 750,000, of which 33 percent is francophone. The RHAs have a mandate to deliver services to all segments of the population.

Hospital programs are divided into three general categories of complexity or resource intensity and distributed to allow the system to be as equitable as is clinically and financially feasible. Primary care in the hospital system is delivered in all facilities. Secondary care, which is specialized care requiring more sophisticated and complicated diagnostic procedures and treatment is, for the most part, found in larger facilities. More specialized services, such as nuclear medicine, would be found in the eight regional hospitals. Tertiary services are found only in a few designated centres, and in some cases these services may be designated as a provincial service. For example, the Cardiac Surgery Unit located in Region 2 (Saint John) has a provincial mandate.

On May 8, 2002, the Government of New Brunswick introduced a legislative package to expand the role of nurses to make fuller use of their skills and training in treating illness and promoting better health. The *Nurses and Nurse Practitioners' Act* came into force on June 7, 2002. When fully implemented, these changes will reduce patient waiting times in doctors' offices and hospital emergency rooms.

New Brunswick, like other jurisdictions, is dealing with the sustainability of its health care system. Total expenditures for the Department of Health and Wellness are approximately 28 percent of total government spending. The Department's budget has been increasing at a greater rate than the entire provincial budget. In 2001-2002, the Department's actual expenditures increased by 10.8 percent, while provincial expenditures increased by 4.1 percent.

On April 1, 2001, the Department of Health and Wellness introduced "A Nursing Resource Strategy for New Brunswick" that will be phased in over three years. The Strategy will enhance the ability of Regional Health Authorities to recruit and retain nurses.

In April, 2001, New Brunswick adopted a "Wellness Strategy." The key elements to guide our actions to help New Brunswickers to stay healthier include: health promotion and prevention; the determinants of health; linking wellness and illness; shared responsibility; collaboration and partnership; empowering communities; government leadership and healthy public policy; best practices; evidence and research; measuring, monitoring, tracking progress and public reporting; citizen participation; and long-term commitment.

Additional information may be obtained on the government website [www.gnb.ca], which has a link to the Department of Health and Wellness website.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

In New Brunswick, the health care insurance plan is known as the Medical Services Plan. The public authority responsible for operating and administering the Plan is the Minister of Health and Wellness, whose authority rests under the *Medical Services Payment Act* and its Regulations, which were proclaimed on January 1, 1971.

The Act and Regulations specify eligibility criteria, the rights of the beneficiary, and the responsibilities of the provincial authority, including the establishment of a medical service plan, the insured, and the uninsured services. The legislation also stipulates the type of agreements the provincial authority may enter into with provinces and territories and with the New Brunswick Medical Society. As well, it specifies the rights of a medical practitioner, how the amounts to be paid for entitled services will be determined, how assessment of accounts for entitled services may be made, and confidentiality and privacy issues as they relate to the administration of the Act.

The Minister of Health and Wellness is responsible for establishing a medical services plan that identifies beneficiaries, which services are and are not covered, and the amounts to be paid for entitled services. Under the Plan, the Minister assesses and audits physician billings through inspectors appointed by him or her and through a professional review committee as defined in sections 24(1) to 33 of the Medical Services Payment Act Regulations. The Minister also has the authority to recover the cost of entitled services from a person who is negligent.

1.2 Reporting Relationship

The Medicare Branch of the Public Health and Medical Services Division of the Department of Health and Wellness are mandated with the administration of the Medical Services Plan. The Minister reports both through the Department's Annual Report or through the regular legislative processes.

In February, 2000, the Government of New Brunswick adopted a framework for Region Hospital Corporation accountability as outlined in the document *Building on our Strengths: A Framework for Region Hospital Corporation Accountability*. This document outlined the respective roles of the Department and the RHAs, and established the RHA System Planning Committee as the key process that supports RHA accountability.

1.3 Audit of Accounts

Three groups have the mandate to audit in the area of the Medical Services Plan.

1. The Auditor General

- In accordance with the *Auditor General Act*, the Office of the Auditor General conducts the external audit of the accounts of the Province of New Brunswick, which include the financial records of the Department of Health and Wellness. For 2001-2002 all transactions of the Department were subject to audit. These procedures are completed on a routine basis each year. Following the audit, the Auditor General issues a management letter or report to identify errors and control weaknesses.

2. The Office of the Comptroller

- The Comptroller is the chief internal auditor for the Province of New Brunswick and carries out internal audit activity in accordance with responsibilities and authority under the *Financial Administration Act*. The objective of an internal audit is to fulfill the Comptroller's mandate as it relates to the Appropriations Audit, Information Systems Audit, Statutory Audits and Value-for-Money Audits. The audit work performed by the Office varies, depending on the nature of the entity audited. No reviews were done in fiscal 2001-2002.

3. Department of Health and Wellness Internal Audit

- The Department's Internal Audit Group was established to independently review and evaluate departmental activities as a service to all levels of management. This group is responsible for providing management with information about the adequacy and the effectiveness of its system of internal controls and adherence to legislation and stated policy. The unit performs program audits to report on the effectiveness of programs in meeting departmental objectives. Reviews of program areas are usually done on a cyclical basis with a major program covered once every three to four years. No reviews were performed on these programs for 2001-2002.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Legislation providing for insured hospital services includes:

- the *Hospital Services Act*, 1973, and section 9 of Regulation 84-167 identifies entitled services, and
- the *Hospital Act*, assented to May 20, 1992 and its Regulation 92-84.

There are eight Regional Health Authorities (RHA), established by legislation. Each RHA includes a regional facility and a number of smaller facilities, all of which provide insured services to both in- and out-patients. Each RHA has other health facilities or health centres, without designated beds, that provide a range of services to entitled persons. See Appendix 1 to this section of the report for a listing of RHA facilities by type. Note that facilities are categorized as those providing in-patient beds and those that do not provide in-patient services.

Under Regulation 84-167 of the *Hospital Services Act*, New Brunswick residents are entitled to the following insured hospital services:

> "(a) in-patient services in a hospital facility operated by an approved regional health authority as follows:
>
> (i) accommodation and meals at the standard ward level,
>
> (ii) necessary nursing service,
>
> (iii) laboratory, radiological and other diagnostic procedures, together with the necessary interpretations, for the purpose of maintaining health, preventing disease and assisting in the diagnosis and treatment of any injury, illness or disability,
>
> (iv) drugs, biologicals and related preparations, as provided for in Schedule 2,
>
> (v) use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies,
>
> (vi) routine surgical supplies,
>
> (vii) use of radiotherapy facilities, where available,
>
> (viii) use of physiotherapy facilities, where available, and
>
> (ix) services rendered by persons who receive remuneration therefor from the regional health authority; and
>
> (b) out-patient services in a hospital facility operated by an approved regional health authority as follows:
>
> (i) laboratory and diagnostic procedures, together with the necessary interpretations, when referred by a medical practitioner or nurse practitioner, where approved facilities are available,
>
> (i.1) laboratory and diagnostic procedures together with the necessary interpretations, where approved facilities are available, when performed for the purposes of a mammography screening service that has been approved by the Minister, and
>
> (ii) the hospital component of available out-patient services when prescribed by a medical practitioner or nurse practitioner and provided in the out-patient facility of an approved regional helath authority for the purpose of maintaining health, preventing disease and assisting in the diagnosis and treatment of any injury, illness or disability, excluding the following services:
>
> (A) the provision of any proprietary medicines;
>
> (B) the provision of medications for the patient to take home;
>
> (C) diagnostic services performed to satisfy the requirements of third parties, such as employers and insurance companies;
>
> (D) visits solely for the administration of drugs, vaccines, sera or biological products; and
>
> (E) any out-patient service which is an entitled service under the *Medical Services Payment Act*."

2.2 Insured Physician Services

The enabling legislation providing for insured physician services in New Brunswick is the *Medical Services Payment Act* (MSPA).

The MSPA was given assent on December 6, 1968. Regulation 84-29 was filed on February 13,1984, Regulation 93-143 on July 26,1993, Regulation 96-113 on November 29, 1996 and Schedule 4 (surgical-dental services) Regulation 84-20 was filed on April 13,1999.

No changes were introduced in 2001-2002.

The New Brunswick Medical Services Plan covers physicians who provide medically required services. The conditions a physician must meet to participate in the New Brunswick Medical Services Plan are:

- to maintain current registration/licence with the New Brunswick College of Physicians and Surgeons;
- membership in the New Brunswick Medical Society;
- holding privileges in a Region Hospital Corporation; and
- signing the Participating Physicians Agreement.

The number of practitioners participating in New Brunswick's *Medical Services Payment Act* as of March 31, 2002, was 1,353.

Physicians in New Brunswick have the option to opt out totally or for selected services. Opted-out practitioners are not paid directly by Medicare for the services they render and they must bill their patients directly in all cases. Patients are not entitled to reimbursement from Medicare.

The opting-out provision may not be invoked in the case of an emergency or for continuation of care commenced on an opted-in basis. Opted-in practitioners wishing to opt out for a service must first obtain the patient's agreement to be treated on an opted-out basis, after which they may bill the patient directly for the service. In these cases, the following procedure must be adhered to in every instance. The practitioner must advise the patient in advance and:

a) if the charges do not exceed the Medicare tariff, the practitioner must complete the specified Medicare claim forms and indicate the exact total amount charged the patient. The beneficiary seeks reimbursement by certifying on the claim form that the services have been received and by forwarding the claim form to Medicare;

b) if the charges are to be in excess of the Medicare tariff, the practitioner must inform the beneficiary prior to rendering the service that:

   - they are opting out and charging fees above the tariff;
   - in accepting service under these conditions the beneficiary waives all rights to Medicare reimbursement; and
   - the patient is entitled to seek services from another practitioner who participates in the Plan.

The physician must obtain a signed waiver from the patient on the specified form and forward it to Medicare.

As of March 31, 2002, no physicians rendering health care services had elected to opt out of the Plan.

The range of entitled services under Medicare New Brunswick includes the medical portion of all services rendered by medical practitioners that are medically required. It also includes certain surgical-dental procedures when performed either by a physician or by a dental surgeon in a hospital facility.

An individual, a physician or the Department of Health and Wellness may request the addition of a new service. All requests are considered by the New Service Items Committee, which is jointly managed by the New Brunswick Medical Society and the Department. The decision to add a new service is usually based on conformity to "medically necessary" and whether the service is considered generally acceptable practice (not experimental) within New Brunswick and the rest of Canada. Considerations under the term "medically necessary" include services required for the purpose of maintaining health, preventing disease and /or diagnosing or treating an injury, illness or disability. No public consultation process is used.

2.3 Insured Surgical-Dental Services

The range of surgical-dental services under New Brunswick Medicare are payable only to oral and maxillofacial surgeons. A general dental practitioner may be paid to assist another dentist for services that are medically required to be performed in a hospital and are included in Schedule 4 of Regulation 84-20 (filed June 23, 1998) under the *Medical Services Payment Act*. Schedule 4 identifies the insured surgical-dental services that can be provided by a qualified medical practitioner in a hospital, if the condition of the patient requires services to be rendered in a hospital.

The conditions a dental practitioner must meet to participate in the medical plan are maintaining current registration with the New Brunswick Dental Society and completing the Participating Physician's Agreement (included in the New Brunswick Medicare Dental registration form).

The number of dental practitioners registered with New Brunswick Medicare is 52, although many do not provide insured services.

Dentists have the same opting-out provision as previously explained for physicians and must follow the same guidelines. The Department of Health and Wellness has no data for the number of non-enrolled dental practitioners in New Brunswick.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Uninsured hospital services include:

- ☐ patent medicines;
- ☐ take-home drugs;
- ☐ third-party requests for diagnostic services;
- ☐ visits for the administration of drugs, vaccines, sera or biological products;
- ☐ televisions, telephones;
- ☐ preferred accommodation at the patient's request; and
- ☐ hospital services directly related to services listed under Schedule 2 of the Regulation under the *Medical Services Payment Act*.

Services are not insured if provided to those entitled under other statutes.

There are no specific policies or guidelines, other than the Act and Regulations, to ensure that charges for uninsured medical goods and services (i.e., enhanced medical goods and services such as intra-ocular lenses, fibreglass casts, etc.) provided in conjunction with an insured health service do not compromise reasonable access to insured services.

Uninsured Physician and Surgical-Dental Services

The services listed in Schedule 2 of the Regulation (84-20) under the *Medical Services Payment Act* are specifically excluded from the range of entitled services under Medicare, namely:

"*(a)* elective plastic surgery or other services for cosmetic purposes;

(a.01) correction of inverted nipple;

(a.02) breast augmentation;

(a.03) otoplasty for persons over the age of 18;

(a.04) removal of minor skin lesions, except where the lesions are or are suspected to be pre-cancerous;

(a.1) abortion, unless the abortion is performed by a specialist in the field of obstetrics and gynaecology in a hospital facility approved by the jurisdiction in which the hospital facility is located and two medical practitioners certify in writing that the abortion was medically required;

(a.2) surgical assistance for cataract surgery unless such assistance is required because of risk of procedural failure, other than the risk inherent in the removal of the cataract itself, due to the existence of an illness or other complication;

(b) medicines, drugs, materials, surgical supplies or prosthetic devices;

(c) vaccines, sera, drugs and biological products listed in sections 106 and 108 of New Brunswick Regulation 88-200 under the *Health Act*;

(d) advice or prescription renewal by telephone which is not specifically provided for in the Schedule of Fees;

(e) examinations of medical records or certificates at the request of a third party, or other services required by hospital Regulations or medical by-laws;

(f) dental services provided by a medical practitioner;

(f.1) services that are generally accepted within New Brunswick as experimental or that are provided as applied research;

(f.2) services that are provided in conjunction with or in relation to the services referred to above;

(h) testimony in a court or before any other tribunal;

(i) immunization, examinations or certificates for purposes of travel, employment, emigration, insurance, or at the request of any third party;

(j) services provided by medical practitioners to members of their immediate family;

(k) psychoanalysis;

(l) electrocardiogram (E.C.G.) where not performed by a specialist in internal medicine or paediatrics;

(m) laboratory procedures not included as part of an examination or consultation fee;

(n) refractions;

(n.1) services provided within the Province by medical practitioners or dental practitioners for which the fee exceeds the amount payable under this Regulation;

(o) the fitting and supplying of eyeglasses or contact lenses;

(p) transsexual surgery;

(p.1) radiology services provided in the Province by a private radiology clinic;

(q) acupuncture;

(r) complete medical examinations when performed for purposes of a periodic check-up and not for medically necessary purposes;

(s) circumcision of the newborn;

(t) reversal of vasectomies;

(u) second and subsequent injections for impotence;

(v) reversal of tubal ligations;

(w) intrauterine insemination;

(x) gastric stapling or gastric by-pass; and

(y) venipuncture for the purposes of the taking of blood when performed as a stand-alone procedure in a facility that is not an approved hospital facility."

Dental services not specifically listed in Schedule 4 of the Dental Schedule are not covered by the Plan. Those listed in Schedule 2 are considered the only non-insured medical services.

The decision to de-insure physician or surgical-dental services is based on the conformity of the service to the definition of "medically necessary," a review of medical services plans across the country and the previous utilization of the particular service. Once a decision to de-insure is reached, the *Medical Services Payment Act* dictates that the Government may not make any change to the Regulation until the advice and recommendation of the New Brunswick Medical Society is received or until the period within which the Society was requested by the Minister to furnish advice and make recommendations has expired. Subsequent to the receipt of their input and resolution of any issues, a regulatory change is completed. Physicians are informed in writing following notification of approval. The public is usually informed through a media release. No public consultation is used.

No medical or surgical-dental services were removed from the insured service list in 2001-2002.

3.0 Universality

3.1 Eligibility

The *Medical Services Payment Act* and its Regulation 84-20 sections 3 and 4 define eligibility for the health care insurance plan.

Residents are required to complete a Medicare application and to provide proof of Canadian citizenship, Native status or a valid Canadian immigration permit. A resident is defined as a person lawfully entitled to be or to remain in Canada, who makes his or her home and is ordinarily present in New Brunswick, but does not include a tourist, transient or visitor to the Province.

All persons entering or returning to New Brunswick have a waiting period prior to becoming eligible for coverage. Coverage commences the first day of the third month following the month of arrival. An exception was made to grant first-day coverage for bona fide missionaries who were previously registered residents of New Brunswick at the time of their departure from the country.

Residents who are ineligible include:

- ☐ regular members of the Canadian Armed Forces;
- ☐ members of the Royal Canadian Mounted Police;
- ☐ federal inmates;
- ☐ persons moving to New Brunswick as temporary residents;
- ☐ a family member who moves from another province to New Brunswick in advance of other members;
- ☐ persons who have entered New Brunswick from another province for the purpose of furthering their education and who are eligible to receive coverage under the medical services plan of that province; and
- ☐ non-Canadians who are issued certain types of Canadian immigration permits (e.g., a Student Authorization).

Provisions to become eligible include:

- ☐ non-Canadians who are issued an immigration permit that would not normally entitle them to coverage are eligible if legally married to an eligible New Brunswick resident.

Provisions when status changes include:

- ☐ persons who have been discharged or released from the Canadian Armed Forces, the RCMP or a federal penitentiary. Provided they are residing in New Brunswick at the time, these persons are eligible for coverage on their date of release. They must complete an application, provide the official date of release or discharge and provide proof of citizenship.

3.2 Registration Requirements

A beneficiary who wishes to become eligible to receive entitled services shall register, together with any dependants under the age of 19, on a form provided by Medicare for this purpose, or be registered by a person acting on his or her behalf.

Upon approval of the application, the beneficiary and dependants are registered and a Medicare card with an expiry date is issued to the beneficiary and each dependent.

A Notice of Expiry form providing all family information currently existing on the Medicare files is issued to the beneficiary two to three months prior to the expiry date of the Medicare card(s). A beneficiary who wishes to remain eligible to receive entitled services is required to confirm the information on the Notice of Expiry, to make any changes as appropriate and to sign and return the form to Medicare. Upon receipt of the completed form the file is updated and new card(s) issued bearing a revised expiry date.

Currently in New Brunswick, only those individuals deemed eligible are actually registered.

All family members, i.e., the beneficiary, spouse and dependants under the age of 19 are required to register as a family unit. Residents who are co-habiting, but not legally married, are eligible to register as a family unit if they so request.

The number of residents registered as of March 31, 2002, was 737,299.

Residents may opt out if they choose. They are asked to provide a written confirmation of their intention. This information is added to their files and benefits are terminated. As of March 31, 2002, only three residents had elected to opt out of the Plan.

3.3 Other Categories of Individual

Non-Canadians who may be issued an immigration permit that would not normally entitle them to Medicare coverage are eligible provided they are legally married to an eligible New Brunswick resident and remain in possession of a valid immigration permit. At the time of renewal, they are required to provide an updated immigration document. In 2001-2002, approximately 50 individuals were covered under these conditions.

4.0 Portability

4.1 Minimum Waiting Period

There is a three-month waiting period. Coverage commences the first day of the third month following the month of arrival.

4.2 Coverage During Temporary Absences in Canada

The legislation that defines portability of health insurance during temporary absences in Canada is the Medical Services Payment Act, Regulation 84-20 sections 3(4) and 3(5).

Students in full-time attendance at a university or other approved educational institution who leave New Brunswick to further their education in another province are granted coverage for a 12 month period that is renewable provided they:

☐ contact Medicare once in every 12 month period to retain their eligibility;

☐ do not establish residence outside New Brunswick; and,

☐ do not receive health coverage in another province.

Residents temporarily employed in another province or territory are granted coverage for up to 12 months provided they:

☐ do not establish residence outside the Province;

☐ do not receive coverage in another province or territory; and

☐ intend to return to New Brunswick.

If absent longer than 12 months, residents should apply for coverage in the Province or territory where they are employed and should be entitled to coverage there on the first day of the thirteenth month.

New Brunswick has formal agreements with all provinces and territories for the reciprocal billing of insured hospital services. As well, New Brunswick has reciprocal agreements with all provinces except Quebec for the provision of insured physicians' services. Services provided by Quebec physicians to New Brunswick patients are paid at Quebec rates, if the services are insured in New Brunswick. The majority of such claims are received directly from Quebec physicians. Any paid claims submitted by the patient are reimbursed to the patient according to New Brunswick Regulations.

During 2001-2002, New Brunswick paid to other provinces and territories:

Hospital In-patient	Hospital Out-patient	Medical Services
$19,110,500	$5,261,500	$8,257,500

4.3 Coverage During Temporary Absences Outside Canada

The legislation that defines portability of health insurance during temporary absences outside Canada is the Medical Services Payment Act, Regulation 84-20 sections 3(4) and 3(5).

Students in full-time attendance at a university or other approved educational institution, who leave New Brunswick to further their education in another country, will be granted coverage for a 12 month period that is renewable provided they:

☐ provide proof of enrolment;

☐ contact Medicare once every 12 month period to retain their eligibility;

☐ do not establish permanent residence outside New Brunswick; and

☐ do not receive health coverage elsewhere.

Temporary Workers: Residents temporarily employed outside the country are granted coverage for up to 12 months, regardless if it is known beforehand that they will be absent beyond the 12 month period, provided they do not establish residence outside the country. Any absence over 182 days, whether it be for work purposes or vacation, would require "Director's

Approval". This approval can only be up to 12 months in duration and only be granted once every three years. Families will continue to be covered, provided they reside in New Brunswick.

Exception to Temporary Workers: Mobile Workers are residents whose employment requires them to travel frequently outside the Province. Certain guidelines must be met to receive Mobile Worker designation. They are:

- applications must be submitted in writing;
- documentation is required as proof of Mobile Worker status, e.g., a letter from an employer or a photocopy of an Immigration Permit;
- permanent residence must remain in New Brunswick; and
- the person must return to New Brunswick during their off-time.

Mobile Worker designation is assigned for a maximum of three years, after which the resident must reapply and resubmit documentation to confirm status.

For teachers employed in Louisiana there is a special provision for a maximum two-year coverage.

New Brunswick Medicare covers out-of-country medical and hospital services for emergency out-patients and resulting in-patient services only. Medicare pays New Brunswick rates for physician services associated with the emergency interventions. The associated facility rates, paid in Canadian funds, are: in-patient $100 per day, and out-patient $50 per visit.

Medicare will cover out-of-country services that are not available in Canada on a prior approval basis only. Residents may opt to seek non-emergency out-of-country services; however, those who receive such services will assume responsibility for the total cost. During 2001-2002, New Brunswick paid the following amounts for services received outside of Canada:

Hospital In-patient	Hospital Out-patient	Medical Services
$440,088	$133,360	$332,600

4.4 Prior Approval Requirement

New Brunswick residents may be eligible for reimbursement if they receive elective medical services outside the country, provided they fulfill certain requirements, which are:

- the required service must be unavailable in Canada;
- it must be rendered in a hospital listed in the current edition of the American Hospital Association Guide to the Health Care Field (Guide to United States Hospitals, Health Care Systems, Networks, Alliances, Health Organizations, Agencies and Providers);
- the service must be rendered by a medical doctor; and
- the service must be an accepted method of treatment recognized by the medical community and be scientifically proven. Experimental procedures are not covered.

If the above requirements are met, it is mandatory to request prior approval from Medicare in order to receive coverage. The physician, patient or family member may request prior approval to receive these services outside the country, accompanied by supporting documentation.

The following are considered exemptions under the out-of-country coverage policy:

- haemodialysis: patients will be required to obtain prior approval and Medicare will reimburse the resident at a rate equivalent to the interprovincial rate; and
- allergy testing for environment sensitivity: all tests sent outside the country will be paid at a maximum of $50 per day, an amount equivalent to an out-patient visit.

Prior approval is also required for referral of patients to psychiatric hospitals and centres outside the Province, because they are excluded from the Interprovincial Reciprocal Billing Agreement. A request for prior approval must be received from the referring physician(s).

5.0 Accessibility

5.1 Access to Insured Health Services

Since there are no health care user fees in New Brunswick, all residents have equal access to insured health services.

5.2 Access to Insured Hospital Services

The New Brunswick Hospital Master Plan identifies the number of approved beds by the Region Hospital Corporation. The number of approved beds is shown in the following table.

Approved Beds as of March, 2002

Bed Type		Number	Percent of Total Beds
Non-Tertiary	Acute	2,878	72
	Restorative	397	10
	Addictions	174	4
	Corrections Canada	2	0
	Veterans Affairs Canada	187	5
	Sub-Total	3,638	91
Tertiary	Oncology	80	2
	Cardiac Surgery	26	1
	Neurosurgery	46	1
	Tertiary Psychiatry	206	5
	Tertiary Rehabilitation	20	0
	Sub-Total	378	9
Provincial Total		4,016	100

All facilities that provide *Canada Health Act* insured services have the appropriate medical, surgical, rehabilitative and diagnostic equipment or systems corresponding to their designated levels of care. As of March 31, 2002, there were nine Computed Tomography (CT) scanners operating in the Province, one in each of the eight Regional Health Authorities, with an additional unit in the Atlantic Health Sciences Corporation (Region #2). The Province also has a mobile Magnetic Resonance Imaging (MRI) unit in operation, and three fixed-site MRI systems.

In 2001-2002, the following initiatives served to improve access to insured hospital services in New Brunswick:

- the introduction of two fixed-site MRIs at the Region 1 Health Authority (Beauséjour), and Region 2 Health Authority, Saint John; and
- the establishment of a mobile service in Regions 5, 6 and 7.

5.3 Access to Insured Physician and Dental-Surgical Services

A total of 689 general/family practitioners, 799 specialists, five dentists, five oral surgeons and two orthodontists provided insured services in New Brunswick during fiscal 2001-2002.

In fiscal 2001-2002, the Department continued work on a recruitment and retention strategy aimed at attracting newly licensed family practitioners and specialists that was announced in 1999-2000. This included, in part: utilization of a contingency fund to allow the Department to more effectively respond to potential recruitment opportunities, providing location grants of $25,000 for family practitioners and $40,000 for specialists willing to practise in hard-to-recruit for areas; purchasing five additional seats at Shebrooke University Medical School (September 2002), increasing government involvement in post-graduate training of family physicians, maintaining the summer rural preceptorship program for medical students at 30 positions, and moving physician remuneration toward relative parity with other Atlantic jurisdictions.

5.4 Physician Compensation

A new tentative agreement has been reached for the fee-for-service physicians that will provide a 15 percent increase over three years (2002-2003 to 2004-2005). Discussions are on-going to address the details of the agreement.

There is no formal negotiation process for dental practitioners.

Payments to physicians and dentists are governed under the *Medical Services Payment Act*, Regulations 84-20, 93-143, 96-113.

The methods used to compensate physicians for providing insured health services in New Brunswick are fee-for-service, salary, and sessional or alternate payment mechanisms that may also include a blended system.

5.5 Payments to Hospitals

The primary acts of legislation governing payments to hospital facilities in New Brunswick are the *Hospital Act*, which governs the administration of hospitals, and the *Hospital Services Act*, which governs the financing of hospitals.

There were no changes during fiscal year 2001-2002 affecting the hospital payment process.

The Department utilizes two components to distribute available funding to the Regional Health Authorities.

The main component is a "Current Service Level" (CSL) base. This component addresses five main patient-care delivered services as follows:

- ☐ tertiary services (cardiac, dialysis, oncology);
- ☐ psychiatric services (psychiatric units and facilities);
- ☐ dedicated programs (e.g., addiction services);
- ☐ community-based services (Extra-Mural Program; health service centres); and
- ☐ general patient care.

Added to this are non-patient care support services (e.g., general administration, laundry, food services, energy).

The CSL approach establishes base budgets for the eight RHAs for the above-noted programs and services, with measures for population and service volumes. The base budgets are then adjusted annually for inflation and other factors such as centrally negotiated labour rates.

The population-based funding distribution formula was enhanced in 2000-2001. This methodology attempts to predict the appropriate distribution of available funding for the Regional Health Authorities based on demographic characteristics and current market share of patient volumes, with cases measured by "Resource Intensity Weights." Currently, this methodology is more suitable to in-patient volumes because of a lack of case grouping and weighting methodologies for out-patient volumes, especially tertiary out-patient services, (e.g., oncology and haemodialysis).

The current budget process may extend over more than one fiscal year and includes several steps. By January of each year, the RHAs provide the Department with their utilization data and revenue projections for the following fiscal year, as well as their actual utilization data and revenue figures for the first nine months of the current year. These, along with the audited financial statements from the prior two years, are used to evaluate the expected funding level for each RHA.

Budget amendments are provided during the year to allow for adjustments to applicable programs and services on either recurring or non-recurring bases. The "year-end settlement process" reconciles the total annual approved budget for each RHA to its audited financial statements and reconciles budgeted revenues and expenses to actual revenues and expenses.

6.0 Recognition Given to Federal Transfers

The Province routinely recognizes the federal role regarding its contributions under the Canada Health and Social Transfer (CHST) through public documentation presented through the legislative or administrative processes.

These include:

- ☐ the Budget Papers presented by the Minister of Finance on March 26, 2002;
- ☐ the Public Accounts presented by the Minister of Finance on December 5, 2001; and
- ☐ the Main Estimates presented by New Brunswick's Minister of Finance on March 26, 2002.

New Brunswick does not produce promotional documentation on its insured medical and hospital benefits.

7.0 Extended Health Care Services

The New Brunswick Long Term Care program, a non-insured service, was transferred to the Department of Family and Community Services (DFCS) on April 1, 2000. Nursing home care is also provided through the Nursing Home Services Program of DFCS. Other adult residential care services and facilities are available through a variety of agencies and funding sources within the Province.

Residential and Extended Care Services

The table below identifies residential and extended-care services available in New Brunswick as of March 31, 2002. Nursing homes are private not-for-profit organizations, except for one that is owned by the Province. In order to be admitted to a nursing home, clients go through an evaluation process based on specific health condition criteria.

Adult Residential Facilities are for the most part private for-profit organizations. The number of available beds fluctuates constantly as private entrepreneurs open or close residences. Clients are admitted after going through the same evaluation process used for nursing homes.

Public housing units are available for low-income elderly persons. Admission criteria are based on age and financial situation. The Victorian Order of Nurses (VON) offers support services to some units.

Availability of Residential and Extended Care

Service	Number of Units or Beds
Nursing Home Beds	4,140
Adult Residential Facilities* (beds)	5,341
Public Housing (Units)	2,088
Provincial Total	11,569

* Includes Special Care Homes and Community Residences

Ambulatory Health Care

In New Brunswick, "ambulatory health care" includes services provided in hospital emergency rooms, day/night care in hospitals, and in clinics as may be available in hospital facilities and health centres. This is considered an insured service under the provincial Hospital Services Plan.

Extra-Mural Program

The New Brunswick Extra-Mural Program, also called the "hospital at home" program, is an active treatment program of acute, palliative and long-term health care provided in community environments, (e.g., an individual's home, nursing home, or public school). The eight Regional Health Authorities have been responsible for the delivery of the Extra-Mural Program since 1996. Service providers include nurses, social workers, dieticians, respiratory therapists, physiotherapists, occupational therapists, and speech language pathologists. This service is considered an insured service under the provincial Hospital Services Plan.

Appendix 1: New Brunswick Hospital Facilities, 2002

Regional Health Authority	Facilities Providing Insured Health Services *(Location)*	Other Facilities / Health Centres *(Location)*
Regional Health Authority 1 (South-East)	The Albert County Hospital Inc. *(Albert)* The Moncton Hospital *(Moncton)* The Sackville Memorial Hospital *(Sackville)*	Petitcodiac Health Centre *(Petitcodiac)* Health Services, Rexton *(Rexton)*
Regional Health Authority 1	Hôpital Docteur Georges L. Dumont *(Moncton)* L'Hôpital Stella Maris de Kent *(Sainte-Anne-de-Kent)*	Centre médical régional de Shédiac (Shédiac)
Regional Health Authority 2	Saint John Regional Hospital Facility *(Saint John)* The Charlotte County Hospital Facility *(St. Stephen)* Sussex Health Centre Facility *(Sussex)* St. Joseph's Hospital Facility *(Saint John)* The Grand Manan Hospital Limited Facility *(Grand Manan Island)* Centracare Saint John Inc. * *(Saint John)*	Campobello Health Centre Facility *(Campobello Island)* Deer Island Health Centre Facility *(Deer Island)* Fundy Hospital Association Limited Facility *(Black's Harbour)*
Regional Health Authority 3	Northern Carleton Hospital *(Bath)* Queens North Health Complex *(Minto)* Oromocto Public Hospital *(Oromocto)* L'Hotel-Dieu Saint-Joseph de Perth-Andover Inc. *(Perth-Andover)* Dr. Everett Chalmers Hospital *(Fredericton)* The Tobique Valley Hospital *(Plaster Rock)* Stan Cassidy Centre for Rehabilitation* *(Fredericton)* The Carleton Memorial Hospital *(Woodstock)*	MacLean Memorial Hospital *(McAdam)* Chipman Health Services Centre *(Chipman)* Upper Miramichi Health Services Centre *(Doaktown)* Upper Miramichi Health Services Centre *(Boiestown)* Stanley Health Services Centre *(Stanley)* Fredericton Junction Health Services Centre *(Fredericton Junction)* Harvey Community Hospital *(Harvey Station)*
Regional Health Authority 4	L'Hôpital régional d'Edmundston *(Edmundston)* Grand Falls General Hospital Inc. *(Grand Falls)* L'Hotel-Dieu Saint Joseph de Saint-Quentin Inc. *(Saint-Quentin)*	Centre de Santé de Ste Anne de Madawaska *(Sainte-Anne-de-Madawaska)*
Regional Health Authority 5	L'hôpital régional de Campbellton *(Campbellton)* Restigouche Hospital Centre Inc. **(Campbellton)* L'Hôpital St. Joseph de Dalhousie *(Dalhousie)*	Centre de santé de Jacquet River *(Belledune)*
Regional Health Authority 6	L'hôpital régional Chaleur *(Bathurst)* Centre hospitalier de l'Enfant-Jesus inc. *(Caraquet)* Centre hospitalier de Lamèque *(Lamèque)* Centre hospitalier de Tracadie *(Tracadie)*	Centre de santé de Paquetville *(Paquetville)* Centre de santé de Chaleur *(Pointe Verte)*
Regional Health Authority 7	Miramichi Regional Facility *(Miramichi)*	Baie Ste. Anne Health Centre *(Baie Ste-Anne)* Neguac Health Centre *(Neguac)* Blackville Health Centre *(Blackville)* Rogersville Health Centre *(Rogersville)*

Notes
1. "Insured Health Services" are defined in the *Canada Health Act*
2. Addictions Services, Veterans Units, and Extra-Mural Program Units are not identified on this list.

* indicates provincial tertiary centre

Quebec

Statement from Quebec

In this report, the information pertaining to Quebec is presented in the same way as in the previous annual reports prepared by Health Canada to meet the legislative requirements that have existed since the adoption of the *Canada Health Act*.

The government of Quebec, owing to its constitutional jurisdiction in the area of health, is accountable to the National Assembly and to Quebeckers for its management of health services. In that connection, it regularly makes public various documents and reports on, among other things, the health of the population, patient satisfaction and the organization of health and social services in its territory. Most of these documents can be accessed on the Internet site of Quebec's Ministère de la Santé et des Services sociaux at www.msss.gouv.qc.ca and that of the Régie de l'assurance maladie du Québec at www.ramq.gouv.qc.ca.

Federal Response to Quebec

The Federal Minister of Health is accountable to Parliament and to Canadians regarding the monitoring of compliance by provinces and territories with the *Canada Health Act*. Section 23 of the *Canada Health Act* requires that an annual Report to Parliament be prepared by no later than December 31 of each year on the Act's administration and operation for the preceding fiscal year. The annual report is to include "all relevant information on the extent to which provincial health care plans have satisfied the criteria, and the extent to which the provinces have satisfied the conditions, for payment under this Act". The provincial and territorial governments are the source of the information required for fulfilling this statutory reporting obligation.

In 1999, the Auditor General of Canada recommended that "in its annual reports to Parliament, Health Canada should clearly indicate the extent to which each provincial and territorial health care insurance plan has satisfied the *Canada Health Act* criteria and conditions. Where it does not provide this information in the reports, it should clearly explain the reasons." In responding to the Auditor General's recommendation that *Canada Health Act* monitoring and compliance assessment activities be improved, Health Canada worked collaboratively with the provinces and territories during 2000 and 2001 to implement a standardized format for the Canada Health Act Annual Report and expanded the content to enable a better understanding of whether the *Canada Health Act* is being complied with by provinces and territories.

All provinces and territories were advised of the change in format and content requirements, including a statistical annex that provides a quantitative context for the administration and operation of the *Canada Health Act*. Officials from provinces and territories were offered technical advice and assistance in the completion of their submissions through numerous teleconferences and multilateral meetings. All provinces and territories, Quebec excepted, agreed to fulfill the revised format and content required.

The federal government is concerned that Quebec is not providing sufficient information to effectively assess compliance with the *Canada Health Act* and satisfy the recommendations of the Auditor General. The federal government will continue to work with Quebec to ensure that information is made available to demonstrate compliance with the *Canada Health Act*.

Quebec

Public Administration

Hospital Insurance and Medical Care Plans

The hospital insurance plan, the *Régime d'assurance-hospitalisation du Québec*, is administered by the Ministère de la Santé et des Services sociaux [Quebec department of health and social services] (MSSS).

The health insurance plan, the *Régime d'assurance-maladie du Québec*, is administered by the *Régie de l'assurance maladie du Québec* [Quebec health insurance board], a public body established by the provincial government and responsible to the Minister of Health and Social Services. Both plans are operated on a non-profit basis, and all books and accounts are audited by the Auditor General of Quebec.

Comprehensiveness

Hospital Insurance Plan

The network of institutions under the Ministère de la Santé et des Services sociaux includes the hospital centres, certain residential and long-term care centres (formerly hospital centres for long-term care)[1] and the local community service centres (CLSCs).

The treatment of physical and mental illness is provided by the hospital centres and by some of the residential and long-term care centres.

Insured in-patient services are provided in the in-patient units of the hospital centres, whereas insured out-patient services are available mainly in residential institutions and local community service centres.

Insured in-patient services include: standard ward accommodation and meals; necessary nursing services; routine surgical supplies; diagnostic services; use of operating rooms, delivery rooms and anaesthetic facilities; medications, prosthetic and orthotic devices that can be integrated with the human body; biologicals and related preparations; use of radiotherapy, radiology and physiotherapy facilities; and services rendered by hospital centre staff.

Out-patient services include: clinical services for psychiatric care; electroshock, insulin and behaviour therapies; emergency care; minor surgery (day surgery); radiotherapy; diagnostic services; physiotherapy; occupational therapy; inhalation therapy, audiology, speech therapy and orthoptic services; and other services or examinations required under Quebec legislation.

Other services covered by insurance are: mechanical, hormonal or chemical contraception services; surgical sterilization services (tubal ligation or vasectomy); reanastomosis of the fallopian tubes or vas deferens; and ablation of a tooth or root when the health status of the person makes hospital services necessary.

The MSSS administers an ambulance transportation program free of charge to persons aged 65 or older.

Uninsured hospital services include: plastic surgery; in-vitro fertilization; private or semi-private room at the patient's request; televisions; telephones; drugs and biologicals ordered after discharge from hospital; and services covered by the *Act respecting industrial accidents and occupational diseases* or other federal or provincial legislation.

Medical Care Plan

The services insured by the medical care plan, the *Régime de soins médicaux*, include medical and surgical services provided by physicians, as well as oral surgery, performed in hospital centres or in a university institution determined by regulation, by dental surgeons and specialists in oral and maxillo-facial surgery.

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[1] Since October 1, 1992, hospital centres for long-term care and residential centres have been included in a single institutional category (the CHSLD—*centres d'hébergement et de soins de longue durée* [residential and long-term care centres]), although no change has been made to their specific missions.

The following services are not considered insured:

- any examination or service not related to a process of cure or prevention of illness;
- psychoanalysis of any kind, unless such service is rendered in an institution authorized for this purposes by MSSS;
- any service rendered solely for aesthetic purposes;
- any refractive surgery, except in cases where there is documented failure for astigmatism of more than 3.00 diopters or for anisometropia of more than 5.00 diopters, measured at the cornea, when corrective lenses or corneal lenses are worn;
- any consultation by telecommunication or by correspondence;
- any service rendered by a professional to his or her spouse or children;
- any examination, expert appraisal, testimony, certificate or other formality required for legal purposes or by a person other than the one who has received an insured service, except in certain cases;
- any visit made for the sole purpose of obtaining the renewal of a prescription;
- any examinations, vaccinations, immunizations or injections, where the service is provided to a group or for certain purposes;
- any service rendered by a professional on the basis of an agreement or a contract with an employer, an association or an organization;
- any adjustment of eyeglasses or contact lenses;
- any surgical ablation of a tooth or tooth fragment performed by a physician, except where the service is provided in a hospital centre in certain cases;
- all acupuncture procedures;
- injection of sclerosing substances and the examination done at that time;
- thermography or mammography used for screening purposes, unless this service is delivered on a doctor's order in a place designated by the Minister, in either case, to a recipient who is age 35 or older, on condition that such an examination has not been performed on the recipient in the previous year;
- tomodensitometry, magnetic resonance imaging and use of radionuclides *in vivo* in a human, unless these services are rendered in a hospital centre;
- ultrasonography, unless this service is rendered in a hospital centre or, for obstetrical purposes, in a local community service centre (CLSC) recognized for that purpose;
- any radiological or anaesthetic service provided by a physician if required with a view to providing an uninsured service, with the exception of a dental service provided in a hospital centre, or, in case of a radiology service, if required by a person other than a physician or dentist;
- any sex-reassignment surgical service, unless it is provided on the recommendation of a physician specializing in psychiatry and is provided in a hospital centre recognized for this purpose; and
- any services that are not associated with a pathology and that are rendered by a physician to a patient between 18 and 65 years of age, unless that individual is the holder of a claim card, for colour blindness or a refraction problem, in order to provide or renew a prescription for eyeglasses or contact lenses.

In addition to the basic insured services, the Régie also covers the following, with some limitations for certain residents of Quebec as defined by the *Health Insurance Act* and for employment assistance recipients: optometric services; dental care for children and employment assistance recipients, and acrylic dental prostheses for employment assistance recipients; prostheses, orthopaedic appliances, locomotion and postural aids, and other equipment that helps with a physical disability; external breast prostheses; ocular prostheses; hearing aids, assistive listening devices and visual aids for people with a visual or auditory disability; and permanent ostomy appliances.

Since January 1, 1997, in terms of drug insurance, the *Régie* covers, over and above its regular clientele (employment assistance recipients and persons 65 years of age or older), individuals who do not have access to a private drug insurance plan. The new drug insurance plan covers 3.2 million insured persons.

Universality

Hospital Insurance and Medical Care Plans

Registration with the hospital insurance plan is not required. Registration with the *Régie de l'assurance maladie du Québec* or proof of residence is sufficient to establish eligibility. All persons who reside or stay in Quebec must be registered with the *Régie de l'assurance maladie du Québec* to be eligible for health insurance programs. Services received by regular members of the Canadian Forces, members of the Royal Canadian Mounted Police and inmates of federal penitentiaries are not covered by the plan. No premium payment exists.

Portability

Hospital Insurance and Medical Care Plans

Minimum Period of Residence

Persons settling in Quebec after moving from another province of Canada are entitled to coverage under the Quebec health insurance plan when they cease to be entitled to benefits from the Province of origin, provided they register with the Régie.

If outside Quebec for 183 days or more, students and full-time unpaid trainees may retain their status as residents of Quebec, in the first case for four consecutive calendar years at most, and in the second case for two consecutive calendar years at most. Quebec government civil servants, employees of non-profit organizations with head offices in Canada who are employed abroad in aid or cooperation programs recognized by the Minister of Health and Social Services, and the spouses and dependants of all such persons maintain their status as residents of the Province, provided they notify the Régie of their absence.

This is also the case for persons living in another province for the purpose of seeking employment, holding temporary employment or working on contract there. Their resident status can be maintained for no more than two consecutive calendar years.

Persons employed or working on contract outside Quebec for a company headquartered in Quebec, or employed by the federal government and posted outside Quebec also retain their status as residents of the Province, provided their families remain in Quebec or they retain a dwelling there.

Status as a resident of the Province is also maintained by persons who remain outside the Province for 183 days or more, but less than 12 months within a calendar year, provided such absence occurs only once every seven years and provided they notify the *Régie* of the absence.

Certain categories of resident, notably permanent residents under the *Immigration Act* and persons returning to Canada to live, become eligible under the Plan following a waiting period of up to three months. Persons receiving last resort financial assistance are eligible upon registration. Members of the Canadian Forces and Royal Canadian Mounted Police who have not acquired the status of Quebec resident become eligible upon their arrival, and inmates of federal penitentiaries become eligible upon release. Immediate coverage is provided to seasonal workers, repatriated Canadians, persons from outside Canada who are living in Quebec under an official bursary or internship program of the *Ministère de l'Education* [Quebec department of education], and refugees. Persons from outside Canada who have work permits and are living in Quebec for the purpose of holding an office or employment for a period of six months become eligible for the plan following a waiting period.

Payment for Services in Canada

Hospital costs incurred in another province or in a territory of Canada are paid in accordance with the terms and conditions of the interprovincial agreement on reciprocal billing in the area of hospital insurance that was agreed on by the provinces and territories of Canada. In-patient costs are paid at standard ward rates approved by the host province or territory, and out-patient costs or the costs of expensive procedures are paid at approved standard interprovincial/territorial rates. However, since November 1, 1995, Quebec reimburses the Ottawa hospital only at the average rate for specialized centres in the Outaouais when an Outaouais resident is hospitalized in a university centre in Ottawa for non-urgent care or services available in the Outaouais.

The costs of medical services incurred in another province or a territory of Canada are reimbursed at the amount actually paid or the rate that would have been paid by the Régie for such services in Quebec, whichever is less. However, Quebec has negotiated a permanent arrangement with Ontario to pay Ottawa doctors at the Ontario fee rate for emergency care and when the specialized services provided are not offered in the Outaouais region. This agreement became effective November 1, 1989. A similar agreement was signed in December 1991 for the Abitibi-Témiscamingue/North Bay area.

Payment for Services Outside Canada

As of September 1, 1996, hospital services provided outside Canada in cases of emergency or sudden illness are reimbursed by the Régie, usually in Canadian funds, to a maximum of C$100 per day if the patient was hospitalized (including day surgery) or to a maximum of C$50 per day for out-patient services.

However, haemodialysis treatments are covered to a maximum of C$220 per treatment. In such cases, the Régie reimburses the associated professional services. The services must be dispensed in a hospital or hospital centre recognized and accredited by the competent authorities. No reimbursements are made for nursing homes, spas or similar establishments.

Students, unpaid trainees, Quebec government officials posted abroad, missionaries and employees of non-profit organizations working under programs of international aid or cooperation recognized by MSSS must contact the *Régie* to ascertain their eligibility. If the *Régie* recognizes them as having special status, they receive full reimbursement of hospital costs in case of emergency or sudden illness, and 75 percent reimbursement in other cases.

Costs for insured services provided by physicians, dentists, oral surgeons and optometrists are reimbursed at the rate that would have been paid by the Régie to a health professional recognized in Quebec, up to the amount of the expenses actually incurred. The costs of all services insured in the Province are reimbursed at the Quebec rate, usually in Canadian funds, when they are incurred abroad.

Beneficiaries requiring medical services in hospital abroad for services unavailable in Quebec or elsewhere in Canada are reimbursed 100 percent with prior consent for medical and hospital services that meet certain conditions. Consent is not given by the plan's officials if the hospital service in question is available in Quebec or elsewhere in Canada.

Permanent Moves out of the Province

Insured persons who leave Quebec to settle in other parts of Canada are covered for up to three months after leaving the Province.

Coverage is discontinued as of the day of departure for insured residents who move permanently to another country.

Accessibility

Hospital Insurance and Medical Care Plans

Reasonable Access

Everyone has the right to receive adequate health care services without any kind of discrimination.

There is no extra-billing by Quebec physicians. While the majority of physicians practise within the provincial plan, Quebec allows two other options: professionals who have withdrawn from the Plan and practise outside the Plan, but agree to remuneration in accordance with the provincial fee schedule; and non-participating professionals who practise outside the Plan entirely, so that neither they, nor their patients, receive reimbursement from the *Régie*.

On March 31, 2002, Quebec had 125 institutions operating as hospital centres for a clientele suffering from acute illness, with 21,819 acute and psychiatric care beds for persons with physical or psychiatric ailments allotted to these institutions. From April 1, 2000, to March 31, 2001[2], Quebec hospital institutions had nearly 725,700 admissions for short stays and close to 283,000 registrations for day surgeries. These hospitalizations and registrations accounted for more than represented a total number of more than 5,554,614 patient-days.

Payment to Hospital Centres

The funding of a hospital centre by the Minister of Health and Social Services is done by means of payments in respect of the cost of insured services provided.

The payments made in 2000-2001[3] to institutions operating as hospital centres for insured health services provided to persons living in Quebec amounted to more than $6 billion; payments to hospital centres outside Quebec amounted to approximately $75 million.

Payment for Medical Care

Physicians are paid in accordance with the negotiated fee schedule. Physicians who have withdrawn from the health insurance plan are paid directly by the patient in accordance with the fee schedule after the patient has collected from the *Régie*. Non-participating physicians are paid directly by the patients according to the amount charged.

Reasonable Compensation

Provision is made in law for reasonable compensation for all insured health services rendered by health professionals. The Minister may enter into, with the organizations representing any class of health professional, an agreement prescribing a different rate of compensation for medical services in a territory where the number of professionals is considered insufficient. The Minister may also provide for a different rate of compensation for general practitioners and medical specialists during the first years of practice, depending on the territory or the activity involved. These provisions are preceded by consultation with the organizations representing the professional groups.

In 2001-2002, the *Régie* paid $2,731.3 million to doctors in the povince, while the amount evaluated for medical services outside the province reached $9.4 million.

Extended Health Care Services

Intermediate care, adult residential care and home care services are available, with admission coordinated on a regional level and based on a single assessment tool. The local community service centres (CLSCs) receive individuals, evaluate their care requirements and either arrange for the provision of such services as day-centre programs or home care, or refer them to the appropriate agencies.

MSSS offers some home care services, including nursing care and assistance, homemaker services and medical surveillance.

Residential facilities and long-term care units in acute-care hospitals focus on the maintenance of their clients' autonomy and functional capacities of their clients by providing them with a variety of programs and services, including health care services.

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[2] Latest year for which figures are available

[3] Latest year for which figures are available

Ontario

Introduction

Ontario has one of the largest and most complex publicly funded health care systems in the world, which is administered by the Ministry of Health and Long-Term Care (MOHLTC).

MOHLTC is responsible for providing services to the Ontario public through such programs as health insurance, drug benefits, assistive devices, care for the mentally ill, home care, community support services, public health, and health promotion and disease prevention. It also regulates and funds hospitals and long-term care facilities (nursing homes and homes for the aged), operates psychiatric hospitals and medical laboratories, and co-ordinates emergency health services.

Good health and a readily accessible, accountable, high-quality healthcare system for the people of Ontario were top priorities for the Ontario government in 2001-2002. These priorities were reflected in its actual spending of $23.7 billion to MOHLTC, the largest in provincial history.

In January 2002, Ontario released the results of the Public Dialogue on Healthcare, one of the largest quantitative consultations ever conducted in the province's history. More than 400,000 households responded to a survey mailed to four million Ontario households, more than three times the normal rate for a government direct mail initiative.

Through the Public Dialogue Ontarians told the government that they want their one-tier, universally accessible, publicly funded healthcare system sustained and improved. Four priority areas for improvement were highlighted:

- ❑ increasing the number of doctors and nurses in the system;
- ❑ reducing waiting lists;
- ❑ providing improved access to early diagnostic tools to catch illnesses earlier; and
- ❑ refocusing the health care system to help keep people well in the first place.

These four priorities are the focus of Ontario's efforts to reform the province's health care system.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The Ontario Health Insurance Plan (OHIP) is administered on a non-profit basis by MOHLTC.

OHIP was established under the *Health Insurance Act*, Revised Statutes of Ontario, 1990, c. H-6, to provide insurance in respect of the cost of insured services provided in hospitals and health facilities and by physicians and other health care practitioners.

There were no amendments to the *Health Insurance Act* or its regulations in 2001-2002, which changed the name or public authority of OHIP.

1.2 Reporting Relationship

OHIP is administered by MOHLTC, which regularly reports to the public. For example, as a core business, activities associated with Ontario health insurance are included in MOHLTC's annual Business Plan.

1.3 Audit of Accounts

MOHLTC is audited annually by the Provincial Auditor. The Provincial Auditor's 2002 Annual Report, which was released on December 3, 2002, examined MOHLTC spending on community mental health services and long-term care facilities activities.

MOHLTC's accounts and transactions are published annually in the Public Accounts of Ontario. The 2001-2002 Public Accounts of Ontario was released on November 7, 2002.

2.0 Comprehensiveness

2.1 Insured Hospital Services

The *Health Insurance Act*, and Regulation 552 under that Act govern insured hospital services in Ontario. The Act and Regulation define both in-patient and out-patient insured services.

Insured in-patient hospital services include:

- accommodation and meals at the standard ward level;
- necessary nursing services;
- laboratory, radiological and other diagnostic procedures;
- drugs, biologicals and related preparations; and
- use of operating rooms, obstetrical delivery rooms and anaesthetic facilities.

Insured out-patient services include:

- laboratory, radiological and other diagnostic procedures;
- use of radiotherapy, occupational therapy, physiotherapy and speech therapy facilities, where available;
- use of diet counselling services;
- use of home renal dialysis and home hyperalimentation equipment, supplies and medication;
- provision of equipment, supplies and medication to haemophiliac patients for use at home;
- cyclosporine to transplant patients;
- zidovudine, didanosine, zalcitabine and pentamidine to patients with HIV infection;
- biosynthetic human growth hormone to patients with endogenous growth hormone deficiency;
- drugs for treatment of cystic fibrosis and thalassemia;
- erythropoietin to patients with anaemia of end-stage renal disease;
- alglucerase to patients with Gaucher disease;
- clozapine to patients with treatment-resistant schizophrenia; and
- the administration of a rabies vaccine.

In addition to insured hospital benefits, Ontario provides a range of services, including long-term care services, mental health services (including the operation of provincial psychiatric hospitals), the residential component of the Homes for Special Care Program, ambulance services (air and land) with a patient co-payment component, dental treatments for patients with cleft lip-palate who are registered at a designated clinic, and funding for a breast cancer screening program, etc.

The *Public Hospitals Act* is the enabling legislation for public hospitals in Ontario and includes Regulation 964 on the Classification of Hospitals and Regulation 965 on Hospital Management.

In 2001-2002 there were 154 public hospital corporations (excluding speciality hospitals, private hospitals, provincial psychiatric hospitals, federal hospitals and long-term care facilities) staffed and in operation in Ontario. This includes 139 acute care hospital corporations, 11 chronic care hospitals and 4 general and special rehabilitation units. Facilities are categorized by major activity, though they provide a mix of hospital services. For example, many acute care hospitals offer chronic care services, just as many chronic care facilities also offer rehabilitation. Public hospitals may be accredited by the Canadian Council on Health Services Accreditation (CCHSA).

When insured physician services are provided in licensed facilities outside hospitals and where the total cost paid for these insured services is not included in the physician fees paid under the *Health Insurance Act*, MOHLTC provides funding through the payment of facility fees under the *Independent Health Facilities Act* (IHFA). Facility fees cover the cost of premises, equipment, supplies and personnel utilized to render an insured service, where these costs are not included in the physician's fee. Under the IHFA, patient charges for facility fees are prohibited.

Facility fees are charged to the government only by facilities that are licensed under the IHFA. Examples of facilities that are licensed under the IHFA include surgical/treatment facilities (providing abortions, cataract surgery, dialysis, non-cosmetic plastic surgery, etc.) and diagnostic facilities (providing x-ray, ultrasound, nuclear medicine, sleep studies and pulmonary function studies). New facilities are ordinarily established through a request for proposals process based on an assessment of need for the service.

2.2 Insured Physician Services

Under subsection 37.1(1) of Regulation 552 of the *Health Insurance Act*, a service rendered by a physician in Ontario is an insured service if it is medically necessary, and is contained in the Schedule of Benefits and rendered in such circumstances or under such conditions as outlined in the Schedule of Benefits.

Physicians are registered to practise medicine in Ontario by the College of Physicians and Surgeons of Ontario. There are approximately 23,100 physicians registered to submit claims to OHIP.

Physicians may submit claims for all insured services rendered to insured persons, directly to OHIP in accordance with section 15, or they may bill the insured person as specified in section 17 of the *Health Insurance Act* (see also the *Health Care Accessibility Act*). Physicians who do not bill OHIP directly are commonly referred to as having "opted-out". When a physician has "opted-out", the physician bills the patient (not exceeding the amount payable for the service in the Schedule of Benefits), and the patient is then entitled to reimbursement by OHIP. The percentage of opted-out physicians has fallen to less than one percent since the enactment of the *Health Care Accessibility Act* in 1986.

Insured physician services in facilities, physicians' offices or in a patient's home are detailed in the Schedule of Benefits, pursuant to Ontario Regulation 552 under the *Health Insurance Act*. In general terms, these include:

- diagnosis and treatment of medical disabilities and conditions;
- medical examinations and tests;
- surgical procedures;
- maternity care;
- anæsthesia;
- radiology and laboratory services in approved facilities; and
- immunizations, injections and tests.

Services may be added to or deleted (de-insured) from the Schedule of Benefits for Physician Services by regulation on the recommendation of the Central Tariff Committee of the Ontario Medical Association in consultation with MOHLTC. The Schedule of Benefits Working Group, comprised of members from the Ontario Medical Association and MOHLTC, continually reviews and revises the Schedule of Benefits to reflect current medical practice and new technologies. Public consultation may also be undertaken.

2.3 Insured Surgical-Dental Services

Approximately 320 dentists and dental/oral surgeons provided insured surgical-dental services in 2001-2002.

Insured hospital surgical-dental services that are medically necessary that they be rendered in hospital, prescribed in section 16 and Schedules 13, 14, and 15 of Regulation 552 under the *Health Insurance Act*, include the following:

- repair of traumatic injuries;
- surgical incisions;
- excision of tumours and cysts;
- treatment of fractures;
- homeografts;
- implants;
- alloplastic reconstructions; and
- all other specified dental procedures.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Only services prescribed by and rendered in accordance with the *Health Insurance Act* and Regulations are insured. All other services are uninsured. Section 24 of Regulation 552 contains a non-exhaustive list of services, which are prescribed as uninsured.

Uninsured hospital services include:

- additional charges for preferred accommodation unless prescribed by a physician, oral-maxillofacial surgeon, or midwife;
- telephones and televisions;
- charges for private-duty nursing;
- cosmetic surgery under most circumstances;
- provision of medications for patients to take home from hospital, with certain exceptions; and
- in-province hospital visits solely for the administration of drugs, subject to certain exceptions.

Uninsured physician services include:

- services that are not medically necessary;
- travelling to visit an insured person outside the area of the practice;
- toll charges for long-distance telephone calls;
- preparing or providing a drug, antigen, antiserum or other substance unless the drug, antigen or antiserum is used to facilitate a procedure;
- advice given by telephone at the request of the insured person or the person's representative;
- an interview or case conference (in limited circumstances);
- preparation and transfer of records at the insured person's request;
- a service that is received wholly or partly for the production or completion of a document or the transmission of information to a "third party" in specified circumstances;
- the production or completion of a document or the transmission of information to any person other than the insured person in specified circumstances;
- provision of a prescription when no concomitant insured service is rendered;
- cosmetic surgery;
- acupuncture procedures;
- psychological testing;
- group screening programs; and
- research and survey programs.

The above list is not exhaustive and is subject to exceptions. For further details, refer to section 24 of Regulation 552 under the *Health Insurance Act*, the Schedule of Benefits for Physician Services, and section 11.2 of the *Health Insurance Act*.

Furthermore, section 11.2(2) of the *Health Insurance Act* provides that services to which a person is entitled under the *Workplace Safety and Insurance Act* (1997), or under the *Homes for Special Care Act* or under any Act of the Parliament of Canada, except the *Canada Health Act*, are not insured services.

"Third-party requests" for services are not generally insured by OHIP.

Ontario's health insurance policy states that enhanced medical goods, such as fibreglass casts, are provided to the patient without charge, where those enhanced medical goods are medically necessary.

It is a provincial offence for a physician to charge patients, or to accept payment from patients, for more than the amount payable by OHIP. A physician may charge for services that are not insured under OHIP. MOHLTC does not regulate charges for uninsured services. The Ontario Medical Association publishes a schedule of suggested fees for uninsured services.

3.0 Universality

3.1 Eligibility

With certain exceptions, all Ontario residents are eligible for coverage, subject to a three-month waiting period. Regulations under the *Health Insurance Act* define those types of persons who are residents of Ontario, as well as those who are subject to the three-month waiting period (For further detail, refer to section 11(1) of the *Health Insurance Act* and Regulation 552 thereunder).

Every resident of Ontario who seeks OHIP coverage is required to register for health insurance. To be considered a resident of

Ontario for the purpose of obtaining OHIP coverage, a person must:

- hold prescribed citizenship or immigration status (section 1.1(1) of Regulation 552, under the *Health Insurance Act*);
- make his or her permanent and principal home in Ontario in accordance with Regulation 552; and
- generally speaking, be physically present in Ontario for at least 153 days in any 12-month period.

With certain exceptions set out in subsection 3(4) of Regulation 552, most new and returning residents are subject to a three-month waiting period. MOHLTC will determine whether or not an individual is subject to a three-month waiting period at the time of the application for health insurance. Former federal inmates and newly determined Convention Refugees are among those who are exempt from the waiting period.

Among those who are ineligible for Ontario health coverage are individuals without citizenship or immigration status as prescribed under section 1.1 (1) of Regulation 552, such as refugee claimants (who are not Convention Refugees). Other categories of individuals such as federal penitentiary inmates are generally not provided with coverage if they are entitled to services under federal legislation (s11.2(2)). Persons previously ineligible for coverage but whose status has changed (e.g., change in immigration status or release from a federal penitentiary) may, upon application, be eligible for OHIP coverage subject to the requirements of Regulation 552.

3.2 Registration Requirements

A health card is issued to eligible residents upon application to the General Manager of OHIP, pursuant to sections 2 and 3 of Regulation 552. Eligible persons should apply for coverage upon establishing permanent residence in the Province. Registration is done through local OHIP offices.

Applicants for Ontario health coverage must complete and sign a Registration for Ontario Health Coverage form and provide MOHLTC with proof of immigration status, residency and identity. Original documents from each category are to be provided by the applicants upon registration. Once eligibility has been determined, applicants over the age of 15½ are generally required to have their photographs and signatures captured for their photo health cards.

Each photo health card has a card renewal/expiry date in the bottom right-hand corner of the card. MOHLTC mails renewal notices to registrants approximately six weeks before the card's renewal date.

MOHLTC is the sole payor for insured health services. An eligible Ontario resident may not register with or obtain any benefits from another insurance plan for any insured service covered by OHIP.

Approximately 12,000,000 Ontario residents were registered with OHIP as of December 3, 2002.

3.3 Other Categories of Individual

MOHLTC provides coverage to several categories of individuals other than Canadian citizens and landed immigrants. Generally, these individuals are required to provide proof of citizenship or acceptable immigration status, residency and identity in the same manner as individuals with permanent resident status who apply for Ontario health coverage. However, applicants from within these categories may also be required to provide specific documentation to confirm their entitlement to OHIP coverage or they may be exempted from certain requirements. Clients applying for coverage under any of these categories should contact their local OHIP office for details. A general overview of eligibility for applicants in other categories is included below.

The following categories of individuals will be eligible if they meet the definition of resident in Regulation 552:

Applicants for Landing – Applicants for Landing are persons who are being processed toward landing by Citizenship and Immigration Canada (CIC) and, generally speaking, have met CIC medical requirements. An immigrant who has been "landed" is a permanent resident of Canada.

Approximately 4,500 individuals were registered as Applicants for Landing as of March 31, 2001.

Convention Refugees – The Immigration and Refugee Board designates a person as a Convention Refugee when that person has been found to fear persecution in his or her country of origin because of race, religion, nationality, membership in a social group, or political opinion. Approximately 76,400 individuals were registered as Convention Refugees as of March 31, 2001.

Minister's Permit Holders – Holders of Minister's Permits are persons who do not meet immigration requirements to remain permanently in Canada. Holders of case types 80 (adoption only), 86, 87, 88, or 89 Minister's Permits who are ordinarily residing in Ontario are eligible for OHIP coverage for the duration of their immigration documents. Holders of case type 90 Minister's Permits are not eligible for OHIP. Approximately 800 individuals were registered as holders of eligible Minister's Permits as of March 31, 2001.

Clergy, Foreign Workers and their Accompanying Family Members – An eligible foreign clergy person is a person who is sponsored by a religious organization or denomination who has finalized an agreement to minister full-time to a religious congregation in Ontario for a period of at least six consecutive months and who is ordinarily a resident of Ontario. Approximately 1,100 individuals were registered as eligible foreign clergy as of March 31, 2001.

A foreign worker is a person who has a finalized contract of employment or an agreement of employment with a Canadian employer situated in Ontario and has been issued an Employment Authorization by Citizenship and Immigration Canada that names the Canadian employer, states the person's prospective occupation, and has been issued an Employment Authorization for a period of at least six months. Approximately 11,400 individuals were registered as eligible foreign workers as of March 31, 2001.

Eligible accompanying family members are the spouses and dependent children (under 19 years of age) of an eligible foreign member of the clergy or an eligible foreign worker who is to be employed for at least three consecutive years and who is ordinarily a resident of Ontario. Approximately 7,700 individuals were registered as eligible accompanying family members as of March 31, 2001.

Migrant Farm Workers – Migrant farm workers are persons who have been issued an Employment Authorization under the Caribbean, Commonwealth and Mexican Seasonal Agriculture Workers Program administered by Citizenship and Immigration Canada. Due to the special nature of their employment, migrant farm workers are not required to present residency documents generally required to establish eligibility for OHIP coverage. Members of this group are also exempt from the three-month waiting period. Approximately 2,900 individuals were registered as migrant farm workers as of March 31, 2001.

Live-in Caregivers – Live-in Caregivers are persons who have been issued an employment authorization under the Live-in Caregivers in Canada Program (LCP) or the Foreign Domestic Movement (FDM) administered by the federal department of Citizenship and Immigration. An eligible Live-in Caregiver is a person who possesses an employment authorization issued by Citizenship and Immigration Canada that indicates LCP or FDM and who is ordinarily a resident of Ontario. The employment authorization for LCP or FDM workers does not have to list the three specific employment conditions required by all other foreign workers, however, the three-month waiting period applies to Live-in Caregivers.

3.4 Premiums

The payment of premiums was abolished in 1990.

4.0 Portability

4.1 Minimum Waiting Period

Individuals who move to Ontario are entitled to OHIP coverage beginning the first day of the third month after establishing residency in Ontario unless listed as an exception in section 3(4) of Regulation 552. These requirements are set out in section 3 of Regulation 552 of the *Health Insurance Act*.

4.2 Coverage During Temporary Absences in Canada

Ontario adheres to the terms of the Interprovincial Agreement on Eligibility and Portability. In accordance with that agreement, insured residents who are outside Ontario temporarily can use their Ontario Health Cards to obtain insured health services. Insured residents who leave Ontario temporarily to travel within Canada without establishing residency in another province or territory will continue to be covered for a period of up to 12 months.

Out-of-province services are covered under sections 28, 30(1) and 32 of Regulation 552 of the *Health Insurance Act*. It is also possible for Ontario residents to maintain continuous health coverage while temporarily working or studying in another Canadian province or territory.

In accordance with the Interprovincial Agreement on Eligibility and Portability, a person insured by OHIP who seeks or accepts employment in another province or territory is provided with OHIP coverage for a maximum of 12 months. If the individual plans to remain outside Ontario beyond the 12-month maximum, he or she should apply for coverage in the province or territory where that person has been working or seeking work.

Insured students who are temporarily absent from Ontario, but remain within Canada, are eligible for continuous health coverage for the duration of their studies, provided they do not establish permanent residency elsewhere during this period. To ensure that they maintain continuous OHIP eligibility, students should provide MOHLTC with letters from their educational institution confirming registration as full-time students. Family members of students who are studying in another province or territory are also eligible for continuous OHIP eligibility while accompanying students for the duration of their studies.

Ontario participates in reciprocal agreements with all other provinces and territories for insured hospital in- and out-patient services. Payment is at the in-patient rate of the plan in the province or territory where hospitalization occurs. Ontario pays the standard out-patient charges authorized by the Coordinating Committee on Reciprocal Billing.

In addition, section 28 of Regulation 552 of the *Health Insurance Act* sets out payment for insured hospital services outside Ontario but within Canada that are not billed through the reciprocal arrangements.

Ontario also participates in reciprocal billing arrangements with all other provinces and territories, except Quebec (which has not signed a reciprocal agreement with any other province or territory), for insured physician services.

4.3 Coverage During Temporary Absences Outside Canada

Coverage during temporary absences outside Canada is governed by sections 28.1 through 29 (inclusive) and section 31 of Regulation 552 of the *Health Insurance Act*.

In accordance with sections 1.1(3), 1.1 (4), 1.1(5) and 1.1(6) of Regulation 552 of the *Health Insurance Act*, MOHLTC may provide insured Ontario residents with continuous OHIP eligibility for absences of longer than 212 days in a 12-month period. In most cases, applicants must provide MOHLTC with a document explaining the reason for their absence from Ontario to qualify for an approved absence. Applicants must also have been present for at least 153 days in each of the two consecutive 12-month periods prior to the expected date of departure in order to be approved for an extended absence.

Approved absences vary in duration depending on the reason for the absence. Refer to the table below for further details.

Reason	OHIP Coverage
Study	Duration of a full-time academic program (unlimited)
Work	Five-year terms
Missionary Work	Duration of missionary activities (unlimited)
Vacation/Other	Up to two years in a lifetime

Family members may also qualify for continuous OHIP eligibility while accompanying the primary applicant on an approved absence and should contact their local OHIP office for details.

Out-of-country services are covered under section 28.1 to 28.6 inclusive, and sections 29 and 31 of Regulation 552 of the *Health Insurance Act*.

Effective September 1, 1995, out-of-country emergency hospital costs are reimbursed at Ontario fixed per diem rates of:

- a maximum $400 Canadian for in-patient services;
- a maximum $50 Canadian for out-patient services; and
- a maximum $210 Canadian per dialysis treatment.

Medically necessary out-of-country physician and other eligible practitioner services (chiropractors, dentists, optometrists, podiatrists and osteopaths) are reimbursed only at the rates listed in MOHLTC's Schedule of Benefits, Regulation 552, or the amount billed, whichever is less. Charges for medically necessary emergency out-of-country in-patient and out-patient services are reimbursed only when rendered in a licensed hospital or health facility. Medically necessary out-of-country laboratory services when done on an emergency basis by a physician are reimbursed in accordance with the formula set out in section 29(1)(b) of the Regulation or the amount billed, whichever is less; and when done on an emergency basis by a laboratory, in accordance with the formula set out in section 31 of the Regulation.

In 2001-2002 payments for out-of-country in-patient and out-patient insured hospital and medical services amounted to $27.5 million for emergency services.

4.4 Prior Approval Requirement

Prior approval is required for payment for elective services provided outside the country. These provisions are set out in section 28.4 of Regulation 552 of the *Health Insurance Act*.

Under section 28.4 of Regulation 552, where medically accepted treatment is not available in Ontario, or in those instances where the patient faces a delay in accessing treatment in Ontario that would threaten the patient's life or cause irreversible tissue damage, the patient may be entitled to full funding of out-of-country health services.

Under section 28.5 of Regulation 552, laboratory tests performed outside Canada are paid for, with prior approval from the Ministry, if the following conditions are met: that kind of service or test is not performed in Ontario; the service or test is generally accepted in Ontario as appropriate for a person in the same circumstances as the insured person; the service or test is not experimental; and the service or test is not performed for research purposes.

There is no formal prior approval process for services provided to Ontario residents outside the province but within Canada. The interprovincial agreement between the provinces includes a schedule for high-cost services. In rare circumstances where this schedule does not cover the costs in another province, Ontario may be asked to guarantee payment before the service is provided.

In 2001-2002, total payments for prior approved treatment outside Canada was $24.1 million.

5.0 Accessibility

5.1 Access to Insured Health Services

All insured hospital, medical and dental services are available to Ontario residents on uniform terms and conditions.

All insured persons are entitled to all insured hospital and medical services, as defined in the *Health Insurance Act*. Public hospitals in Ontario are not permitted to refuse to provide services in life-threatening situations by reason of the fact that the person is not insured. Under the *Health Care Accessibility Act*, physicians (both opt-in and opt-out) are prohibited from charging more than the amount for an insured service than is allowed in the Schedule of Benefits for Physician Services. Extra-billing by physicians is also prohibited. Under that same legislation, hospitals are also prohibited from charging insured residents for insured services.

MOHLTC implemented Health Number/Card Validation to aid health care providers and patients with access to health services and claim payment. Providers may subscribe for validation privileges to verify their patient eligibility and health number/version code status (card status).

If patients require access to health services and do not have a health card in their possession, the provider may obtain the necessary information by submitting to MOHLTC a Health Number Release Form signed by the patient. An accelerated process for obtaining health numbers for patients who are unable to provide a health number and require emergency treatment is available to emergency room facilities through the Health Number Look Up service.

5.2 Access to Insured Hospital Services

In 2001-2002, there were 154 public hospital corporations staffed and in operation in Ontario, which included chronic, general and special rehabilitation units. There were 7,245,186 acute patient days, 2,249,189 chronic patient days and 721,115 rehabilitation patient days delivered by public hospitals during fiscal year 2001-2002.

Some examples of improved access to services are:

- introduction of first pulmonary thromboendarectomy program;
- introduction of a provincial stroke strategy that includes piloting telemedicine at three sites;
- increased cardiac and renal services through implementation of new and expanded programs;
- construction and expansion of cancer centres;
- additional medical and critical care beds to relieve pressure on emergency departments;
- addition of new long-term care beds;
- free tuition to medical students willing to practice in rural and northern areas;
- introduction of a policy to ensure emergency room patients are seen within 15 minutes;
- enhanced pre-school speech and language program;
- invested in treatment of young people with eating disorders; and
- improved access to cervical screening in remote areas.

5.3 Access to Insured Physician and Dental-Surgical Services

Reasonable access to physician services in Ontario is ensured by an adequate supply of physicians.

An Underserviced Area Program (UAP) provides residents of rural and remote areas of Ontario with improved access to general physician services. Six programs enhance access to health services for residents of northern Ontario: the Northern Group Funding Plan and Community Sponsored Contracts provide alternative funding arrangements that pay a group of physicians a global amount (not fee-for-service) for primary care services, the Incentive Grant Program for physicians provides financial assistance to general practitioners and specialists locating to designated underserviced areas and the Northern Health Travel Grant financially assists patients who must travel to receive hospital and specialist medical services, the Free Medical School Tuition initiative provides up to $40,000 in tuition reimbursement and incentive grants if medical students and trainees agree to practice in an underserviced area for a minimum of three years, and the Northern Physician Retention Initiative provides eligible family practitioners and specialists who have maintained practices in northern Ontario for at least four years with a retention incentive and also provides access to continuing education.

The Service Retention Initiative program is designed to encourage family physicians and specialists to maintain services in regions of marked under-supply, and to discourage specialists providing highly sub-specialized services from leaving the province. The program encourages recruitment so that conditions of regional undersupply are reduced or eliminated.

Currently, there are 100 communities in Ontario designated as underserviced by general/family practitioners and 12 communities designated as underserviced by specialists.

As of March 2002, there were approximately 20,915 active physicians who submitted claims to OHIP. Of this total 10,395 (49.7 percent) were family physicians and 10,520 (50.3 percent) were specialists.

Under the Physician Outreach Program, regularly scheduled primary care clinics may be provided to remote communities which have UAP-funded nursing stations and to provide telephone back-up to the nurse/nurse-practitioners working at the nursing station.

5.4 Physician Compensation

Insured services provided by approximately 21,000 of the registered 23,100 physicians and 325 dentists in Ontario are paid primarily on a fee-for-service basis, according to the Schedules of Benefits for Physician Services under the *Health Insurance Act*.

In 2000, the Government of Ontario negotiated a four-year agreement with the Ontario Medical Association to determine funding amounts for physician services with respect to fee-for-service payments. In 2001-2002, fee-for-service physicians were paid $4.7 billion for medical, surgical and diagnostic services provided to Ontario residents.

A Schedule of Benefits Working Group, composed of MOHLTC and Ontario Medical Association representatives, was given the mandate in the agreement to identify changes in the existing Schedule of Benefits that will result in annual savings of at least $50 million. These savings are accomplished through a mix of tightening and modernization initiatives. The first set of recommendations, projected to save $20 million annually, was implemented on August 13, 2001. The remaining $30 million in savings measures is targeted for implementation in the next fiscal year.

The Resource Based Relative Value Schedule (RBRVS) Commission was jointly established in 1997 by the Ontario Medical Association and MOHLTC, with a mandate to recommend a relative value schedule to replace the current OHIP Schedule of Benefits on a revenue-neutral basis. In the summer of 2002 the RBRVS Commission released its report. The report contains a complete review of the methodology used and rationalization for decisions made by the Commission, a review of the consultations with the OMA Sections in February 2002 and a list of all professional fee codes with their assigned relative value units. The report is now available on the RBRVS web site at

http://www.rbrvs.on.ca/c.reports/c.reports.html.

Representatives of government and the Ontario Dental Association negotiate agreements on adjustments to the Plan's Schedule of Benefits that cover insured dental services provided in hospital. In 1999-2000, dental expenditures were $8.1 million. The last funding agreement expired on March 31, 2000, and was extended to March 31, 2001. Discussions for a new multi-year agreement commenced in fall 2000. Discussions with the ODA to develop and implement a new fee schedule and funding proposal began in February 2001. A proposed draft multi-year funding agreement was presented by ODA and modified by MOHLTC in March 2002. The proposed funding agreement is currently under review by MOHLTC.

5.5 Payments to Hospitals

Hospitals submit annual operating plans/business planning briefs that are the product of a broad consultation within the facilities (e.g., all levels of staff, unions, physicians, and board) and within the community and region. The operating plan is first and foremost a planning document but it also has a substantial budget component, both financial and statistical. The District Health Council (DHC) and staff of MOHLTC then review this operating plan. MOHLTC review is conducted by regional staff, specialized program staff and senior management, and follows standard guidelines. It may involve extensive discussions and clarification with the facility.

Payments made by the health care plan to hospitals for insured services come under the *Health Insurance Act* and are calculated on an annual budget basis. The Ontario budget system is a prospective reimbursement system that reflects the effects of workload increases, costs related to provincial priority programs, and cost increases in respect of above-average growth in volume of service in specific geographic locations. Payments are made to hospitals on a semi-monthly basis.

MOHLTC reviews chronic care co-payment regulations and rates periodically, taking into account changes in the Consumer Price Index, Old Age Security, Guaranteed Income Supplement and Guaranteed Annual Income Supplement each year, and determines whether revisions to the regulations and rates are appropriate.

Priority programs are diverse and require highly specialized human resources and infrastructure. The programs are often high-cost and high-growth. They can be associated with newly developed treatments that include advanced therapies and technologies. Generally, these programs are managed provincially and are designed to ensure equitable access. MOHLTC determines funding based on population needs and clinical outcome evidence.

Priority programs include:

- acquired brain injury;
- bone marrow transplantation;
- cardiovascular services;
- cleft lip & palate and craniofacial dental;
- cochlear implants;
- end stage renal disease;
- hemophilia ambulatory clinics;
- hip and knee total joint replacements;
- Magnetic Resonance Imaging;
- organ transplantation;
- paediatric oncology;
- provincial regional genetics program;
- regional geriatric programs;
- sexual assault treatment centres; and trauma.

MOHLTC also manages the following provincial strategies:

- cardiac rehabilitation pilot project;
- Ontario Stroke Strategy;
- Organ and Tissue Donation and Transplantation Action Plan;
- Visudyne Therapy Service; and
- Ontario Joint Replacement Registry.

MOHLTC measures and rewards relative cost efficiency in hospitals through the Integrated Population-Based Allocation model. Payments are made to those hospitals that spend less than expected, taking into consideration the individual characteristics of the hospital.

In addition, specialized methodologies are used for incremental funding for specific policy and program initiatives (i.e. Nursing Enhancements, 60-hour post-partum guarantee length of stay).

Funding for patient care in hospitals was in excess of $8.7 billion for 2001-2002.

6.0 Recognition Given to Federal Transfers

The Government of Ontario publicly acknowledged the federal contributions provided through the Canada Health and Social Transfer in its 2001-2002 publications.

7.0 Extended Health Care Services

Extended health care, funded by MOHLTC, is provided by long-term care facilities (nursing homes and homes for the aged) and home-care service providers. The MOHLTC conducts the compliance monitoring program for long-term care facilities. The Ministry monitors resident health and well-being, safety, security, environmental and dietary services to determine compliance with legislation, regulations and standards. The Ministry receives and monitors the implementation of corrective action plans to achieve compliance, where necessary.

Home-care services (professional services, personal support and homemaking services) are funded by MOHLTC and provided through Community Care Access Centres for people of all ages. MOHLTC funds attendant services for physically disabled adults and supportive housing services for seniors, physically disabled adults, adults with acquired brain injuries and persons living with HIV/AIDS. MOHLTC also funds a variety of community support services such as adult day programs, meal services, and transportation services.

In addition to insured hospital benefits, Ontario provides a wide range of health services, including long-term care community and facility services; mental health services that include the operation of provincial psychiatric hospitals; community-based mental health treatment and support services; the residential component of the Homes for Special Care Program; land and air ambulance services with a patient co-payment; ambulance dispatch services; dental treatments for patients with cleft lip/palate who are registered at a designated clinic; and funding for a breast cancer screening program.

8.0 Additional Materials Submitted to Health Canada

Annual Reports

- Ministry of Health and Long-Term Care Business Plan

  http://www.gov.on.ca/health/english/pub/ministry/bplan01/bplan01.html
- Ministry of Health and Long-Term Care Performance Report 2001-2002

  http://www.gov.on.ca/MOH/english/pub/ministry/pirc/pirc_mn.html
- Hospital Report 2001: Acute Care, Emergency Department Care and Complex Continuing Care

  http://www.gov.on.ca/health/english/contact/hosp/hosprep_mn.html

Audit Reports

- Ontario Health Insurance Plan 1998 (Report of Provincial Auditor):

  www.gov.on.ca/opa/english/e98/306.htm
- Ontario Health Insurance Plan – Follow-up 2000 (Report of Provincial Auditor):

  www.gov.on.ca/fin/english/budeng.htm#public
- 2001 Annual Report of the Office of the Provincial Auditor of Ontario

  http://www.gov.on.ca/opa/english/en01/e01t.htm

Financial Reports

- Budget Papers 2001-2002

  www.gov.on.ca/FIN/english/budeng.htm#Budget
- Public Accounts 2001-2002

  www.gov.on.ca/FIN/english/budeng.htm#public

Legislation

- *Health Insurance Act* and Regulations
- *Public Hospitals Act* and Regulations
- *Independent Health Facilities Act* and Regulations
- *Health Care Accessibility Act* and Regulations

Please note that Ontario statutes and regulations are available at

http://www.e-laws.gov.on.ca

Agreements

- Agreement for Northern and Rural Family Doctors

  http://www.ontariofamilyhealthnetwork.gov.on.ca/english/index.html
- Family Health Network Funding Agreement

  http://www.ontariofamilyhealthnetwork.gov.on.ca/english/index.html

Other Documents

- Shaping Ontario's Physician Workforce (May 2001)

  http://www.gov.on.ca/health/english/pub/ministry/workforce/workforce.pdf
- Good Nursing, Good Health: A good Investment (August 2001)

  http://www.gov.on.ca/health/english/pub/ministry/nurserep01/nurse_rep.html
- A Public Dialogue on Health Care (January 2002)

  http://www.gov.on.ca/health/english/surveys/dialogue_0701/results_mn.html

Manitoba

Introduction

Manitoba has been nationally recognized by the Canadian Institute for Health Information as having the best plan in the country for ending hallway medicine. Through expansions to home care, better coordination of hospital resources, and the largest flu vaccination program in the Province's history, Manitoba managed to decrease the number of hallway patients substantially since the year 2000.

Manitoba's five-point plan to end hallway medicine in hospitals consists of the following measures:

- opening new beds;
- improving admission and discharge procedures;
- expanding community-based services;
- strengthening prevention programs like flu immunization; and
- increasing home care and adult day-care programs.

Manitoba faces the national and global challenge of addressing a shortage of health professionals. Progress is being made to address this shortage through a range of training, recruitment and retention strategies. Manitoba now has among the best ratio of nurses per capita in the country.

Every day, nurses throughout Manitoba demonstrate their commitment to the well-being of Manitobans through the professional, skilled care they provide. In turn, the Manitoba Government has made a commitment to nurses in two key areas. These are:

- the recruitment of adequate numbers of nurses in a variety of areas of nursing; and
- the retention of nurses in workplaces that respect and maximize the professional skills and experience of nurses for the well-being of patients and clients.

On April 2, 2001, the Manitoba Government and the Winnipeg Regional Health Authority (WRHA) announced a plan to convert the Pan Am Clinic into a non-profit facility that will serve as a new service delivery model for Medicare. Under the plan, Pan Am becomes an operating division of the WRHA and functions as part of the regional surgery program. What makes the Pan Am model unique is that the Clinic retains any operating surplus it generates for reinvestment in cutting edge diagnostic, surgical, and other medical equipment and procedures. In this way, Pan Am keeps a major incentive to innovate, and provides competition within the public system, as health care managers gain an alternative service delivery option to traditional hospitals.

Manitoba has approved the purchase and installation of a Gamma Knife, expected to be operational by October, 2003, enhancing the potential for Manitoba to be the focus of excellence in neurosurgery for Western Canada. Stereotactic radiosurgery using a Gamma Knife is a "scalpel-less" surgical procedure that uses low dose radiation beams to treat abnormalities within the brain. Since the procedure is non-invasive, the risk of infection and damage to healthy tissue is markedly reduced. In most cases, patients can receive this form of surgery on a day-surgery basis, rather than spend weeks in hospital following conventional surgery. Over 1,500 studies have been published supporting the use of Gamma Knife radiosurgery. It is now considered the standard of care internationally for a range of neurosurgery conditions.

The Role of Manitoba Health

Manitoba Health is a line department within the government structure and operates under the provisions of statutes and responsibilities charged to the Minister of Health. The formal mandates contained in legislation, combined with mandates resulting from responses to emerging health and health care issues, establish a framework for the planning and delivery of services.

It is the mission of Manitoba Health to provide leadership and support to protect, preserve and promote the health of all Manitobans. This mission is accomplished through a structure of comprehensive envelopes encompassing program, policy, and fiscal accountability; by the development of a healthy public policy; and by the provision of appropriate, effective and efficient health and health care services. Services are provided through regional delivery systems, hospitals and other health care facilities. The Department also makes payments for insured health benefits on behalf of Manitobans related to the costs of medical, hospital, personal care, Pharmacare and other health services.

It is Manitoba Health's vision to lead the way in quality health care, built with creativity, compassion, confidence, trust and respect, empower Manitobans through knowledge, choices and access to the best possible health resources, and build partnerships and alliances for health and supportive communities.

It is also the role of Manitoba Health to foster innovation in the health care system. This is accomplished through developing mechanisms to assess and monitor quality of care, utilization and cost effectiveness; fostering behaviours and environments that promote health; and promoting responsiveness and flexibility of delivery systems, and alternative, less expensive services.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The Manitoba Health Services Insurance Plan (MHSIP) is administered by the Department of Health under *The Health Services Insurance Act*, R.S.M. 1987, c. H35. The Act[1] was significantly amended in 1992, dissolving the Manitoba Health Services Commission and transferring all assets and responsibilities to Manitoba Health. The dissolution took effect on March 31, 1993.

The MHSIP is administered under this Act for insurance in respect of the costs of hospital, personal care and medical services and other health services referred to in Acts of the Legislature or Regulations thereunder. The Act was amended on January 1, 1999, to provide insurance for out-patient services in relation to insured medical services provided in surgical facilities.

The Minister of Health is responsible for the administration and operation of the Plan. Under section 3(2), the Minister has the power:

> "(a) to provide insurance for residents of the province in respect of the costs of hospital services, medical services and other health services, and personal care;
>
> (b) to plan, organize and develop throughout the province a balanced and integrated system of hospitals, personal care homes and related health facilities and services commensurate with the needs of the residents of the province;
>
> (c) to ensure that adequate standards are maintained in hospitals, personal care homes and related health facilities, including standards respecting supervision, licensing, equipment and inspection, or to make such arrangements as the minister considers necessary to ensure that adequate standards are maintained;
>
> (d) to provide a consulting service, exclusive of individual patient care, to hospitals and personal care homes in the province or to make such arrangements as the minister considers necessary to ensure that such a consulting service is provided;
>
> (e) to require that the records of hospitals, personal care homes and related health facilities are audited annually and that the returns in respect of hospitals required by the Government of Canada are submitted; and
>
> (f) in cases where residents do not have available medical and other health services, to take such measures as are necessary to plan, organize and develop medical services and other health services commensurate with the needs of the residents."

The Minister may also enter into contracts and agreements with any person or group that the Minister considers necessary for the purposes of the Act. He or she may also make grants to any person or group for the purposes of the Act on such terms and conditions as considered advisable. Also, the Minister may, in writing, delegate to any person any power, authority, duty or function conferred or imposed upon the Minister under the Act or under the Regulations.

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[1] Where reference is made to "the Act" in the text, this refers to *The Health Services Insurance Act* (1999)

There were no legislative amendments to the Act or the Regulations in the 2001-2002 fiscal year that impacted on the public administration of the Plan.

1.2 Reporting Relationship

Section 6 of the Act requires the Minister to have audited financial statements of the Plan showing separately the expenditures for hospital services, medical services and other health services. The Minister is required to have an annual report prepared, which must include the audited financial statements, and to table the report before the Legislative Assembly within 15 days of receiving it if the Assembly is in session. If the Assembly is not in session, the report must be tabled within 15 days of the beginning of the next session.

1.3 Audit of Accounts

Section 7 of the Act requires that the Office of the Auditor General of Manitoba (or another auditor designated by the Office of the Auditor General of Manitoba) audit the accounts of the Plan annually and prepare a report of that audit for the Minister. The most recent audit reported to the Minister and available to the public is for the 2001-2002 fiscal year and is contained in the *Manitoba Health Annual Report 2001-2002*.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Sections 46 and 47 of the Act, as well as the Hospital Services Insurance and Administration Regulation (M.R. 48/93) provide for insured hospital services.

As of March 31, 2002, there were 97 facilities in Manitoba providing insured hospital services to both in- and out-patients. Hospitals are designated by the Hospitals Designation Regulation (M.R. 47/93) under the Act.

Services specified by Regulation as insured in- and out-patient hospital services include:

- accommodation and meals at the standard ward level;
- necessary nursing services;
- laboratory, radiological and other diagnostic procedures;
- drugs, biologics and related preparations;
- routine medical and surgical supplies;
- use of operating room, case room and anaesthetic facilities; and
- use of radiotherapy, physiotherapy, occupational and speech therapy facilities, where available.

All hospital services are added to the list of available hospital services through the health planning process.

Manitoba residents maintain high expectations for quality health care and insist that the best available medical knowledge and service be applied to their personal health situations. Manitoba Health is sensitive to new developments in the health sciences.

2.2 Insured Physician Services

The enabling legislation that provides for insured physician services is the Medical Services Insurance Regulation (M.R. 49/93) made under the Act.

Physicians providing insured services in Manitoba must be lawfully entitled to practise medicine in Manitoba, registered and licensed under *The Medical Act*. As of March 31, 2002, there were 2,077 physicians on the Manitoba Health Registry.

A physician, by giving notice to the Minister in writing, may elect to collect the fees for medical services rendered to insured persons other than from the Minister, in accordance with section 91 of the Act and section 5 of the Medical Services Insurance Regulation. The election to opt out of the health insurance plan takes effect on the first day of the month following a 90 day period from the date the Minister receives the notice.

Prior to rendering a medical service to an insured person, physicians must give the patient reasonable notice that they propose to collect any fee for the medical service from them or any other person except the Minister. The physician is responsible for submitting a claim to the Minister on the patient's behalf and cannot collect fees in excess of the benefits payable for the service under the Act or Regulations. To date, no physicians have opted out of the medical plan in Manitoba.

The range of physician services insured by Manitoba Health is listed in the Payment for Insured Medical Services Regulation (M.R. 95/96). Coverage is provided for all medically required personal health care services, rendered to an insured person by a physician, that are not excluded under the Excluded Services Regulation (M.R. 46/93) of the Act. During fiscal year 2001-2002, a number of new insured services were added to a revised fee schedule.

In order for a physician's service to be added to the list of those covered by Manitoba Health, physicians must put forward a proposal to their specific section of the Manitoba Medical Association (MMA). The proposals are forwarded to the Manitoba College of Physicians and Surgeons for review to ensure the service is scientifically valid and not developmental or experimental. The MMA will negotiate the item, including the fee, with Manitoba Health. Manitoba Health may also initiate this process.

2.3 Insured Surgical-Dental Services

Insured surgical and dental services are listed in the Hospital Services Insurance and Administration Regulation (M.R. 48/93) under the Act. Surgical services are insured when performed by a certified oral and maxillofacial surgeon or a licensed dentist in a hospital, when hospitalization is required for the proper performance of the procedure. This Regulation also provides benefits in respect of the cost of insured orthodontic services in cases of cleft lip and/or palate for persons registered under the program by their 18th birthdate, when provided by a registered orthodontist. As of March 31, 2002, 541 dentists were registered with Manitoba Health.

Providers of dental services may elect to collect their fees directly from the patient in the same manner as physicians and may not charge to or collect from an insured person a fee in excess of the benefits payable under the Act or Regulations. No providers of dental services had opted out as of March 31, 2002.

In order for a dental service to be added to the list of insured services, a dentist must put forward a proposal to the Manitoba Dental Association (MDA). The MDA will negotiate the fee with Manitoba Health.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

The Excluded Services Regulation (M.R. 46/03) made under the Act sets out those services that are not insured. These include:

- examinations and reports for reasons of employment, insurance, attendance at university or camp, or performed at the request of third parties;
- group immunization or other group services except where authorized by Manitoba Health;
- services provided by a physician, dentist, chiropractor or optometrist to him or herself or any dependants;
- preparation of records, reports, certificates, communications and testimony in court;
- mileage or travelling time;
- services provided by psychologists, chiropodists and other practitioners not provided for in the legislation;
- *in-vitro* fertilization;
- tattoo removal;
- contact lens fitting;
- reversal of sterilization procedures, and
- psychoanalysis.

The Act states that hospital in-patient services include routine medical and surgical supplies, thereby ensuring reasonable access for all residents. The Regional Health Authorities and Manitoba Health monitor compliance.

To de-insure services covered by Manitoba Health the Ministry prepares a submission for approval by Cabinet. The need for public consultation is determined on an individual basis depending on the subject.

No services were removed from the list of those insured by Manitoba Health in 2001-2002.

3.0 Universality

3.1 Eligibility

The Health Services Insurance Act defines the eligibility of Manitoba residents for coverage under the health care insurance plan of the Province. Section 2(1) of the Act states that a resident is a person who is legally entitled to be in Canada, resides in Manitoba, is physically present in Manitoba for at least six months in a calendar year, and includes any other person classified as a resident in the Regulations, but does not include a person who holds a Minister's permit under the *Immigration Act* (Canada), unless the Minister determines otherwise, or is a visitor, transient or tourist.

The Residency and Registration Regulation (M.R. 54/93) extends the definition of residency. The extensions are found in sections 7(1) and 8(1). Section 7(1) allows missionaries, individuals with out-of-country employment, and individuals undertaking sabbatical leave to be outside Manitoba for up to two years while still remaining residents of Manitoba. Students are deemed to be Manitoba residents while in full-time attendance at an accredited educational institution. Section 8(1) extends residency to individuals who are legally entitled to work in Manitoba and have an employment authorization of 12 months or more.

The Residency and Registration Regulation, section 6, defines Manitoba's waiting period as follows:

> "A resident who was a resident of another Canadian province or territory immediately before his or her arrival in Manitoba is not entitled to benefits until the first day of the third month following the month of arrival."

There are currently no other waiting periods in Manitoba.

The Manitoba Health Services Insurance Plan excludes residents covered under the following federal statutes: *Aeronautics Act*; *Civil War Pensions and Allowances Act*; *Government Employees Compensations Act*; *Merchant Seaman's Compensation Act*; *National Defence Act*; *Pensions Act*; *Royal Canadian Mounted Police Act*; *Veterans Rehabilitation Act* or under legislation of any other jurisdiction (Excluded Services Regulations subsection 2(2)). The excluded are residents who are members of the Armed Forces, the Royal Canadian Mounted Police and federal inmates. These residents become eligible for Manitoba Health coverage upon discharge from the Canadian Armed Forces; the RCMP; or an inmate of a penitentiary who has no resident dependants. Upon change of status these persons have one month to register with Manitoba Health (Residency and Registration Regulation (M.R. 54/93, subsection 2(3)).

3.2 Registration Requirements

The process of issuing health insurance cards requires that individuals inform Manitoba Health that they are legally entitled to be in Canada, they intend to be physically present in Manitoba for six months, and they must provide a primary residence address in Manitoba. Upon receiving this information, Manitoba Health will provide a registration certificate for the individual and all qualifying dependants.

Manitoba has two health-related numbers. The registration number is a six-digit number assigned to an individual 18 years of age or older who is not classified as a dependant. This number is used by Manitoba Health to pay for all hospital and medical service claims for that individual and all designated dependants. A nine-digit Personal Health Identification Number (PHIN) is used for the provincial drug program.

During 2001-2002, there were 1,152,982 residents registered with the health care insurance plan.

There is no provision for a resident to opt-out of the Manitoba health plan.

3.3 Other Categories of Individual

The Residency and Registration Regulation, (M.R. 54/93, sub-section 8(1)), requires that temporary workers be in possession of an Employment Authorization issued by Citizenship and Immigration Canada (CIC) for at least 12 months, be physically present in Manitoba and be legally entitled to be in Canada before receiving Manitoba Health coverage.

In 2001-2002, 1244 individuals with Employment Authorizations were covered under the Manitoba Health Services Insurance Plan.

The definition of "resident" under *The Health Services Insurance Act* allows the Minister of Health or the Minister's designated representative to provide coverage for holders of a Minister's permit under the *Immigration Act* (Canada). Five individuals were covered under Minister's permits in 2001-2002.

No legislative amendments to the Act or the Regulations in the 2001-2002 fiscal year had an impact on universality.

4.0 Portability

4.1 Minimum Waiting Period

The Residency and Registration Regulation, (M.R. 54/96, section 6), identifies the waiting period for other insured persons from another province or territory. A resident who lived in another Canadian province or territory immediately before arrival in Manitoba is entitled to benefits upon the first day of the third month following the month of arrival.

4.2 Coverage During Temporary Absences in Canada

The Residency and Registration Regulation, (M.R. 54/93 subsection 7(1)), defines the rules for portability of health insurance during temporary absences in Canada.

Students are considered residents and will continue to receive health coverage for the duration of their full-time enrolment at any accredited educational institution. The additional requirement is that they intend to return and reside in Manitoba upon completion of their studies.

Residents on sabbatical or educational leave from employment will be covered by Manitoba Health for up to 24 consecutive months. These individuals must return and reside in Manitoba upon completion of their leave.

Manitoba has formal agreements with all Canadian provinces and territories for the reciprocal billing of insured hospital services. Manitoba has a bilateral agreement with the Province of Saskatchewan for Saskatchewan residents who receive care in Manitoba border communities.

In-patient costs are paid at standard rates approved by the host province or territory. Payments for in-patient high-cost procedures and out-patient services are based on national rates agreed to by provincial or territorial health plans. These include all medically necessary services as well as costs for emergency care.

With the exception of Quebec, medical services incurred in all provinces or territories are paid through a reciprocal billing agreement at host province or territory rates. Claims for medical services received in Quebec are submitted by the patient or physician to Manitoba Health for payment at host province rates.

In 2001-2002, Manitoba Health made payments totalling approximately $15,204,116 for hospital services and $7,381,785 for medical services provided in Canada.

4.3 Coverage During Temporary Absences Outside Canada

The Residency and Registration Regulation, (M.R. 54/93, sub-section 7(1)), defines the rules for portability of health insurance during temporary absences from Canada.

Residents on full-time employment contracts outside Canada will receive Manitoba Health coverage for up to 24 consecutive months. Individuals must return and reside in Manitoba upon completion of their employment terms. Clergy serving as missionaries on behalf of a religious organization approved as a registered charity under the *Income Tax Act* (Canada) will be covered by Manitoba Health for up to 24 consecutive months. Students are considered residents and will continue to receive health coverage for the duration of their full-time enrolment at an accredited educational institution. The additional requirement is that they intend to return and reside in Manitoba upon completion of their studies. Residents on sabbatical or educational leave from employment will be covered by Manitoba Health for up to

24 consecutive months. These individuals also must return and reside in Manitoba upon completion of their leave.

Coverage for all these categories is subject to amounts detailed in the Hospital Services Insurance and Administration Regulation (M.R. 48/93). Hospital services received outside Canada due to an emergency or sudden attack of illness, while temporarily absent, are paid as follows:

In-patient services are paid based on a per diem rate according to hospital size:

- 1-100 beds: $280
- 101-500 beds: $365
- over 500 beds: $570

Out-patient services are paid at a flat rate of $100 per visit or $215 for haemodialysis.

The calculation of these rates is complex due to the diversity of hospitals in both rural and urban areas.

Manitobans requiring medically necessary hospital services unavailable in Manitoba or elsewhere in Canada may be eligible for costs incurred in the United States by providing Manitoba Health with a recommendation from their specialist stating that the patient requires a specific, medically necessary service. Physician services received in the United States are paid at no less than 100 percent of the equivalent Manitoba rate for similar services. Hospital services are paid at up to 75 percent of the hospital's charges for insured services. Payment for hospital services is made in U.S. funds (the Hospital Services Insurance and Administration Regulation, sections 15-23).

Manitoba Health made payments totalling approximately $5,276,344[2] for hospital care provided in hospitals outside Canada in the 2001-2002 fiscal year. In addition, Manitoba Health made payments totalling approximately $529,029[3] for medical care.

In instances where Manitoba Health has given prior approval for services provided outside Canada and payment is less than 100 percent of the amount billed for insured services, Manitoba Health will consider additional funding based on financial need.

4.4 Prior Approval Requirement

Prior approval is not required for services provided in other provinces or territories. Prior approval is required for elective hospital and medical care provided outside Canada. An appropriate medical specialist must apply to Manitoba Health to receive approval.

No legislative amendments to the Act or the Regulations in the 2001-2002 fiscal year had an impact on portability.

5.0 Accessibility

5.1 Access to Insured Health Services

Manitoba Health ensures that medical services are equitable and reasonably available to all Manitobans. Effective January 1, 1999, the Out-Patient Services in Surgical Facilities Regulation (M.R. 222/98) under *The Health Services Insurance Act* came into force to prevent private surgical facilities from charging additional fees in relation to insured medical services.

In July, 2001, *The Health Services Insurance Act*, *The Private Hospitals Act* and *The Hospitals Act* were amended to strengthen and protect public access to the health care system. The amendments include:

- changes to definitions and other provisions to ensure that no charges can be made to individuals who receive insured surgical services, or to anyone else on that person's behalf; and
- ensuring that a surgical facility cannot perform procedures requiring overnight stays and thereby function as a private hospital.

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[2] This figure does not include the amount paid for exchange on U.S. claims.

[3] This figure does not include the amount paid for exchange on U.S. claims paid under the Critical Shortages Fund.

5.2 Access to Insured Hospital Services

As of March 31, 2002, Manitoba had a total of 3,951 acute care set-up beds and 1,029 other set-up beds (psychiatric extended treatment, palliative, chronic, long-term assessment/ rehabilitation and panelled). These figures include beds located at Selkirk Mental Health Centre (27 acute and 241 other beds) that are now included in the provincial bed map for the first time.

Winnipeg has 2,246 acute care set-up beds, 194 unlicensed personal care home beds, 420 other set-up beds, including two hospitals that provide long-term care and one adolescent psychiatric facility.

In rural and northern Manitoba, there are 1,678 acute care set-up beds and 273 other set-up beds, plus two federal hospitals and 18 federal nursing stations with 93 set-up beds. In addition, rural and northern Manitoba residents have access to Winnipeg acute care set-up beds.

Manitoba Health continues to experience a serious shortage of nurses in all geographic areas. Interest in nursing education continues to be high. Therefore, applications to all nursing programs exceed capacity. Admissions to programs leading to eligibility for licensure as a registered nurse or a licensed practical nurse were in excess of program seats. Response to financial support for refresher courses has been very positive.

Manitoba also has a wide range of other health care professionals. Shortages in some of the technology fields such as radiation therapy, ultrasound technology, Magnetic Resonance Imaging (MRI) technology and lab technicians are also becoming more problematic, with difficulty recruiting for these areas.

Manitoba currently has access to three MRI machines for clinical testing. All units are in Winnipeg. The first unit was installed in 1990 by the St. Boniface Research Foundation and replaced in October, 1998. The second is located at the Health Sciences Centre and became operational in September, 1998. This unit was installed in conjunction with the National Research Council (NRC). The third MRI unit, located in Winnipeg, became operational in January, 2000.

Manitoba has 14 Computerized Tomography (CT) Scanners – and three (one for paediatric patients) at the Health Sciences Centre, two at St. Boniface General Hospital, one each at Victoria General Hospital, Dauphin Regional Health Centre, Thompson General Hospital, Brandon Regional Health Centre, Boundary Trails Health Centre, Misericordia, Seven Oaks, Grace and Concordia Hospitals. As well, there are ultrasound scanners located within Winnipeg health facilities and rural and northern regions. Bone density testing is funded by Manitoba Health on two machines located in Winnipeg and Brandon.

Two linear accelerators have been installed in the redeveloped building at the McCharles site and became operational in December, 2000, and June, 2001. These additional machines ensure the delivery of high quality radiation therapy. The Oncology Day/Evening Hospital was established as part of a larger effort to improve access to treatment in an appropriate care setting. This program allows cancer patients to have long and complex chemotherapy regimens in an out-patient setting.

Manitoba's conversion of the Pan Am Clinic into a non-profit facility under the public umbrella is an exciting innovation that shows how Medicare can and should adapt to the rapid changes in health care today. The Pan Am Clinic is a day surgery centre in Winnipeg that has established itself as a preferred medical environment offering cutting-edge treatments and state-of-the-art technology for muscular-skeletal medicine, including primary care, orthopaedics, rheumatology, and other related services.

5.3 Access to Insured Physician and Dental-Surgical Services

In 2001-2002, Manitoba Health continued to implement several initiatives to improve access to physicians in rural and northern areas of the Province. In July, 2001, as part of the Rural Physician Action Plan, 15 new residency positions which are dedicated to training family physicians for rural practice were added to the Faculty of Medicine. Five residency positions were created to provide rural physicians with advanced residency training. Infrastructure support will be provided through the Office of Rural and Northern Health, under the direction of the Medical Director for the Office, both announced in June of 2002. Manitoba Health's goal is to also have a stand-alone northern office located north of the 53rd parallel.

Manitoba continues to experience small increases in the number of new physicians registering with the licensing body. To encourage retention of Manitoba graduates, the Province introduced a financial assistance grant for students and residents. In return for financial assistance during their training, the student/resident agrees to work in Manitoba for a specific period after graduating. The program was introduced in May, 2001. The Province also introduced a new program to assist Manitoba foreign-trained physicians to achieve licensure. In return for this assistance, the physician agrees to work in an under-serviced area of the Province for a specified period.

The Manitoba Telehealth Network under the leadership of the Winnipeg Regional Health Authority has implemented the infrastructure to link 23 Telehealth sites across the Province. This modern telecommunications link means patients can be seen by specialists and medical staff can consult with each other without having to endure the expense and inconvenience of travelling from the North to Winnipeg. In 2001-2002, Telehealth video conference facilities were added to hospitals in Flin Flon and The Pas.

5.4 Physician/Dentist Compensation

In 1998, Manitoba and The Manitoba Medical Association (MMA) entered into an Interest Arbitration Agreement. This arbitration process culminated in August, 1999, when the Arbitration Board awarded an overall increase to fee-for-service remuneration of 13.4 percent, at a cost of $33.5 million, and instructed the parties to reach agreement on the specific allocation of the overall award. The allocation agreement was finalized in February, 2000. The fee-for-service agreement was effective from April 1, 1998 to March 31, 2002. During this period, the arbitration agreement continued to operate as a dispute resolution mechanism.

Insured services provided by physicians are remunerated through a combination of fee-for-service payments, alternative service arrangements, independent contracts, etc. In 2001-2002, Manitoba had no capitation arrangements in place.

The Payments for Insured Medical Services Regulation (M.R. 51/2001) made under *The Health Services Insurance Act* governs fee-for-service payments to physicians. That Regulation was enacted in the 2000-2001 fiscal year. It repealed the previous Regulation and replaced it to reflect the payments in effect as of February 1, 2001.

Manitoba and the Manitoba Dental Association (MDA) entered into a Memorandum of Agreement effective April 1, 1998, to March 31, 2002. The Agreement provided an overall increase in funding of 13 percent over the four years.

Insured services provided by certified oral and maxillofacial surgeons or licensed dentists are compensated on a fee-for-service basis for specified oral/dental/maxillofacial surgical procedures performed in hospital facilities only.

The Hospital Services Insurance and Administration Regulation (M.R. 48/93) made under *The Health Services Insurance Act* governs payments to dentists for insured dental services. The Regulation was amended in fiscal 2001-2002 to reflect payments in effect as of April 1, 2001.

No amendments to *The Health Services Insurance Act* during 2001-2002 had an impact on Physician/Dentist Compensation.

5.5 Payments to Hospitals

Division 3.1 of *The Regional Health Authorities Act* sets out the requirements for operational agreements between Regional Health Authorities and the operators of hospitals and personal care homes, defined as health corporations under the Act.

Pursuant to the provisions of this division, authorities are prohibited from providing funding to a health corporation for operational purposes unless the parties have entered into a written agreement for this purpose that enables the health services to be provided by the health corporation, the funding to be provided by the authority for the health services, the term of the agreement, and a dispute resolution process and remedies for breaches. If the parties cannot reach an agreement, the Act enables them to request the Minister of Health to appoint a mediator to assist them in resolving outstanding issues. If the mediation is unsuccessful, the Minister is empowered to resolve the matter or matters in dispute and the Minister's resolution is binding on the parties.

The Regional Health Authorities have concluded the required agreements. The operating agreements between the Winnipeg Regional Health Authority and the health corporations operating facilities in Winnipeg will expire March 31, 2006. The operating agreements enable the Authority to determine funding based on objective evidence, best practices and criteria that are commonly applied to comparable facilities.

In addition to the Winnipeg Regional Health Authority, there are two other regional health authorities that continue to have hospitals operated by health corporations in their health regions. In all other regions, the hospitals are operated by the Regional Health Authorities or the federal government. The agreements in place between the Authorities and the health corporations do not have expiry dates and the Authorities are empowered to determine the funding to be provided each year.

The allocation of resources by Regional Health Authorities for the provision of hospital services is approved by Manitoba Health through the approval of the Authorities' regional health plans, which the Authorities are required to submit for approval pursuant to section 24 of *The Regional Health Authorities Act*. Section 23 of the Act requires that Authorities allocate their resources in accordance with the approved regional health plan.

Pursuant to subsection 50(2.1) of *The Health Services Insurance Act*, payments from the Manitoba Health Services Insurance Plan for insured hospital services are to be paid to the Regional Health Authorities. In relation to those hospitals that are not owned and operated by an Authority, the Authority is required to pay each hospital in accordance with any agreement reached between the Authority and the hospital operator.

No legislative amendments to the Act or the Regulations in 2001-2002 had an impact on payments to hospitals.

6.0 Recognition Given to Federal Transfers

Manitoba routinely recognizes the federal role regarding the contributions provided under the Canada Health and Social Transfer in public documents. Manitoba does not advertise or produce promotional material concerning insured or extended health services.

7.0 Extended Health Care Services

Manitoba has established community-based service programs as an appropriate alternative to hospital services. These service programs are provided by Manitoba Health through the Regional Health Authorities. These services include the following.

Personal Care Home Services

The Personal Care Services Insurance and Administration Regulation under *The Health Services Insurance Act* authorizes the provision of services to personal care home residents. Both proprietary and non-proprietary homes are licensed by Manitoba Health. Residents of personal care homes also pay a residential charge. The total Manitoba Health operating expenditures for personal care services during fiscal year 2001-2002 amounted to $362,351,366, supporting a total of 9,611 licensed set-up personal care beds. In addition, there were estimated capital and equipment expenditures of $32,259,507.

Home Care Services

Manitoba Home Care is a province-wide program established to provide effective, reliable and responsive community health care services to support independent living, to develop appropriate care options to support continued community living, and to facilitate admission to institutional care when community living is no longer a viable alternative. Home care services are delivered through the local offices of the

Regional Health Authorities and include a broad range of services based on a multidisciplinary assessment of individual needs. Services may be coordinated by a case coordinator or self-managed and may include personal care assistance, home support, health care, family relief, respite care, supplies and equipment, adult day programs and/or volunteer services.

Ambulatory Health Care Services

The Health Services Insurance Act includes a provision authorizing the designation of non-profit publicly administered ambulatory health (primary care) centres as institutions within the meaning of the Act. There are approximately 10 such institutions receiving funding from Manitoba Health.

Adult Residential Care Services

Residential care facilities are community-based facilities that provide room and board, 24 hour on-site care and supervision, and assistance with activities to ensure that the needs of individual residents are met. These facilities are classified by size: approved homes have up to three adults, and licensed facilities have occupancies of four or more adults.

Residential care facilities are required to be licensed under *The Social Services Administration Act* and Manitoba Regulation (M.R. 484/88 R) and to meet standards established by the Residential Care Licensing Branch of the Department of Family Services and Housing. The Regulations mandate the licensing of facilities for three adult disability categories (mentally ill, mentally disabled, and infirm aged).

There are currently 100 licensed and approved residential care facilities for individuals with mental illness in Manitoba, for a total of 506 bed spaces. There are also 62 mixed facilities for a total of 147 bed spaces. There are 14 licensed and approved facilities for individuals with infirmities of aging, for a total of 162 bed spaces. The majority of residential care facilities are located in Winnipeg and Brandon.

Saskatchewan

Introduction

Saskatchewan is the birthplace of Medicare. Insured hospital services were first provided in Saskatchewan in 1947. Insured physician services followed in 1962, further reinforcing the principle that health services should be provided to individuals based on their health need, not their ability to pay.

Today, in the face of continued debate over the future direction of health care in Canada, Saskatchewan remains committed to this principle. There is recognition, however, that within the boundaries of the publicly funded health care system, there is a need for continued evolution to a more sustainable system that ensures healthier people and healthier communities.

In this context, Saskatchewan was one of the first provinces in Canada to undertake an in-depth review of health care delivery. The recommendations of the Fyke Commission on Medicare formed the basis for several months of careful study and consultation. During these consultations, the Government heard from a wide range of health community partners, as well as residents from across the Province. There was a clear message: Saskatchewan people believe strongly in the continuation of a public medicare system, but recognize the need for change to maintain a strong, responsive system into the future.

As a result of this examination, the Government released *Saskatchewan. Healthy People. A Healthy Province: The Action Plan for Saskatchewan Health Care* in December 2001. This plan provides a long-term blueprint for the Province's health care system to improve the health of Saskatchewan people, while ensuring the best value for every health dollar.

To achieve this vision, the health plan outlines four key goals:

- provide better access to health care services, including primary, hospital and emergency care;
- improve health workplaces and address shortages of key health providers;
- support good health and the prevention of illness for all Saskatchewan people; and
- improve quality, efficiency and accountability measures to ensure long-term sustainability of our medicare system.

Saskatchewan Health will work closely with its health care partners to make the changes needed to strengthen and secure the health care system for the future. The Department has already begun to address many of the specific actions in the Health Plan, aimed at addressing the most pressing issues in the health care system.

For example, in 2002, the Department took steps to improve the management of surgical waiting lists to ensure fair, timely access to surgery for Saskatchewan people. Support for health research was increased in Saskatchewan, to help encourage more effective, evidence-based health care. In addition, as a follow-up to the Action Plan, the Government proposed legislation to replace the 32 health districts with 12 new regional health authorities (RHAs). The legislation for this was implemented in August, 2002.

The new RHAs will work closely with the Department to ensure a coordinated, effective and accountable health system that offers a consistent quality and level of service across the Province. Specifically, regional health authorities will take a lead role in assessing local health needs as well as planning and delivering health services to meet those needs.

RHAs are key partners in a public health system that provides a wide range of hospital, physician, public health, mental health, rehabilitation and addictions services to residents without any direct service charge. The provincial government also contributes to a range of home care, ambulance, pharmaceutical, special care homes and other specialized services with some level of patient co-payment. Other partners in the system include affiliated agencies, fee-for-service physicians, pharmacists, and other health care providers. The provincial government is the major funder of Saskatchewan's health care system, providing approximately $2.2 billion in 2001-2002.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The provincial government is responsible for funding and ensuring the provision of insured hospital, physician and dental-surgical services in Saskatchewan.

Section 6.1 of *The Department of Health Act* (1978) authorizes the Minister of Health to:

- ☐ pay part of or the whole of the cost of providing health services for any persons or classes of person that may be designated by the Lieutenant Governor in Council;
- ☐ pay part of or the whole of the cost of providing health services in any health district or part of a health district in which those services are considered by the Minister to be required; and
- ☐ make grants or provide subsidies to any health agency as the Minister considers necessary.

Sections 8 and 9 of *The Saskatchewan Medical Care Insurance Act* (1998), also known as *The Medical Care Insurance Act*, provide authority for the Minister of Health to establish and administer a plan of medical care insurance for residents.

The Health Districts Act (1993) provides authority for the Lieutenant Governor in Council to establish District Health Boards (section 3) and for District Health Boards to provide services (section 26). Thirty-two District Health Boards were established to provide insured hospital services and a range of other health services. Recently the District Health Boards were replaced by twelve new Regional Health Authorities. *The Regional Health Authorities Act*, effective August 1, 2002, replaced *The Health Districts Act*.

Sections 5 and 11 of *The Cancer Foundation Act* (1997) provide for the establishment of a Saskatchewan Cancer Foundation and for it to coordinate a program for the diagnosis, prevention and treatment of cancer.

The mandates of the Department of Health, District Health Boards, and the Saskatchewan Cancer Foundation for 2001-2002 are outlined in *The Department of Health Act*, *The Health Districts Act* and *The Cancer Foundation Act* as described above. However, *The Regional Health Services Act*, effective August 1, 2002 has replaced *The Health Districts Act*, and now governs our new Regional Health Authorities.

1.2 Reporting Relationship

The Department of Health is directly accountable to and regularly reports to the Minister of Health on the funding and administration of funds for insured physician, surgical-dental and hospital services.

Section 36 of *The Saskatchewan Medical Care Insurance Act* prescribes that the Minister of Health submit an annual report of the medical care insurance plan to the Legislative Assembly.

The Health Districts Act (replaced in August, 2002, by *The Regional Health Services Act*) prescribed that a District Health Board shall, within three months after the end of each fiscal year, submit to the Minister of Health:

- ☐ a report of the District Health Board's service activities and costs;
- ☐ a detailed audited set of financial statements;
- ☐ a report on the health status of the residents of the health district; and
- ☐ a report on the effectiveness of the District Health Board's programs.

Section 35 of *The Health Districts Act* also prescribed that a District Health Board shall submit to the Minister any reports that the Minister may request from time to time.

All District Health Boards are required to submit annual budget plans to Saskatchewan Health. District Health Boards also consult with staff from Saskatchewan Health about matters of concern to either the District Health Board or the Minister of Health.

The Cancer Foundation Act prescribes that the Cancer Foundation shall, in each fiscal year, submit a report about its business and a financial statement to the Minister of Health for the fiscal year immediately preceding.

1.3 Audit of Accounts

The Provincial Auditor conducts an annual audit of government departments and agencies, including Saskatchewan Health. It includes an audit of departmental payments to District Health Boards, the Saskatchewan Cancer Foundation and to physicians and dental surgeons for insured physician and dental-surgical services. The Provincial Auditor may also carry out audits of District Health Boards. The Provincial Auditor independently determines the scope and frequency of its audits based on accepted professional standards.

Section 36 of *The Health Districts Act* prescribed that the accounts of a District Health Board shall be audited at least once in every fiscal year by an independent auditor who possesses the prescribed qualification and is appointed for that purpose by the District Health Board. A detailed audited set of financial statements must be submitted annually by each District Health Board to the Minister of Health. Similar provisions have been made in *The Regional Health Services Act*, effective August 1, 2002.

Section 34 of *The Cancer Foundation Act* prescribes that the records and accounts of the Foundation shall be audited at least once a year by the Provincial Auditor or by a designated representative.

2.0 Comprehensiveness

2.1 Insured Hospital Services

The Department of Health Act (1978) provides for the Department of Health to administer health-related acts (section 5) and outlines the powers and duties of the Minister of Health (section 6), including the powers to pay the costs of health services and to fund organizations providing health services. During 2001-2002, there were no changes made to this legislation.

The Health Districts Act (1993), provides for the establishment of District Health Boards (section 5) to plan and manage the provision of health services (section 26) and authority for the Minister of Health to make grants to District Health Boards for the purposes of the Act (section 32), and to enter into agreements with District Health Boards respecting grants made pursuant to the Act, or any other matter related to the activities or affairs of a District Health Board (section 33). Funding for hospitals is now included in that provided to the health districts.

As of March 31, 2002, the following facilities were providing insured hospital services to both in- and out-patients:

- ☐ sixty-six acute care hospitals provided in- and out-patient services; and
- ☐ one rehabilitation hospital provided treatment, recovery and rehabilitation care for patients disabled by injury or illness. Rehabilitation services are also provided in a geriatric rehabilitation unit in one other hospital and in two special-care facilities.

The Hospital Standards Act and The Hospital Standards Regulations (1980), establish minimum standards for care and certain administrative requirements for hospitals. All hospitals must provide facilities for the provision of treatment services for both in- and out-patients, and must have diagnostic services, x-ray and darkroom space, and a pharmacy to facilitate adequate and accurate dispensing of drugs. The Act also provides for physicians to appeal decisions with respect to the granting of hospital privileges.

The Hospital Standards Act also provides for appointment by the Minister of one or more inspectors to inspect and report on facilities approved under the Act (section 12). The Hospital Standards Regulations (section 103) include the provision that "every hospital may be visited at any time by the Minister, an inspector or any person authorized by the Minister to ensure compliance with the Act and these Regulations."

The Department encourages and supports health districts to obtain district-wide accreditation from the Canadian Council on

Health Services Accreditation (CCHSA). The CCHSA is the major national accrediting body for organizations in all health sectors in Canada. The accreditation process evaluates all aspects of health services delivery from a client-centred perspective. Participating health districts assess and compare their organizations against national quality standards so that they may achieve coordinated, responsive and appropriate programs for all residents. In 2001-2002, 30 health districts participated in the CCHSA accreditation process.

A comprehensive range of insured services is provided by hospitals, which may include:

- public ward accommodation;
- necessary nursing services;
- the use of operating room and case room facilities;
- required medical and surgical materials and appliances;
- x-ray, laboratory, radiological and other diagnostic procedures;
- radiotherapy facilities;
- anaesthetic agents and the use of anaesthesia equipment;
- physiotherapeutic procedures;
- all drugs, biological and related preparations administered in hospital; and
- services rendered by individuals who receive remuneration from the hospital.

No registry or central listing is maintained of the full range of services provided by Saskatchewan hospitals (e.g., no listing is maintained of all nursing services, laboratory, radiological and diagnostic procedures).

District Health Boards have the authority to change the manner in which they deliver insured hospital services based on an assessment of their population health needs and available health professional funding resources.

The process for adding a hospital service to the list of services covered by the health care insurance plan involves a comprehensive review, considering such factors as service need, anticipated service volume, health outcomes by the proposed and alternative services, cost and human resource requirements, including availability of providers as well as initial and ongoing competency assurance demands. Depending upon the specific service request, consultations could involve several branches within Saskatchewan Health as well as external stakeholder groups such as health regions, service providers and the public.

2.2 Insured Physician Services

Sections 8 and 9 of *The Saskatchewan Medical Care Insurance Act* (1998) enable the Minister of Health to establish and administer a plan of medical care insurance for provincial residents.

Amendments were made in June, 2001, and January 1, 2002, to the Physician Payment Schedule of The Saskatchewan Medical Care Insurance Payment Regulations in accordance with an agreement reached with the Saskatchewan Medical Association. Those amendments provided for the addition of new insured physician services and changes in payment levels for selected services.

Physicians may provide insured services in Saskatchewan if they are licensed by the College of Physicians and Surgeons of Saskatchewan and have agreed to accept payment from the Department of Health without extra billing for insured services.

As of March 31, 2002, there were 1,633 physicians licensed to practise in the Province and eligible to participate in the medical care insurance plan. This increase over previous years is partly the result of including locum registrations previously excluded from the active physician counts.

Physicians may opt out or not participate in the Medical Services Plan, but if doing so, must fully opt out of all insured physician services. The opted out physician must also advise beneficiaries that the physician services to be provided are not insured and that the beneficiary is not entitled to reimbursement for those services. Written acknowledgement from the beneficiary indicating that he or she understands the advice given by the physician is also required.

As of March 31, 2002 there were no "opted out" physicians in Saskatchewan.

Insured physician services are those that are medically necessary, are covered by the Medical Services Plan of the Department of Health and are listed in the Physician Payment Schedule of The Saskatchewan Medical Care Insurance Payment Regulations of *The Saskatchewan Medical Care Insurance Act*.

There were approximately 3,000 different insured physician services as of March 31, 2002.

Insured physician services are added to the Medical Services Plan through a process of formal discussion with the Saskatchewan Medical Association. The Executive Director of the Medical Services Branch manages the process of adding a new service. When a new insured physician service is covered by the Medical Services Plan, a regulatory amendment is made to the Physician Payment Schedule. A number of new services were added in 2001-2002.

Although formal public consultations are not held, any member of the public may make recommendations about physician services to be added to the Plan.

2.3 Insured Surgical-Dental Services

Dentists registered with the College of Dental Surgeons of Saskatchewan and designated by the College as specialists able to perform dental surgery may provide insured surgical-dental services under the Medical Services Plan. As of March 31, 2002, 94 dental specialists were providing such services.

Dentists may opt out or not participate in the Medical Services Plan, but if doing so, must opt out of all insured surgical-dental services. The dentist must also advise beneficiaries that the surgical-dental services to be provided are not insured and that the beneficiary is not entitled to reimbursement for those services. Written acknowledgement from the beneficiary indicating that he or she understands the advice given by the dentist is also required.

There were no "opted out" dentists in Saskatchewan as of March 31, 2002.

Insured surgical-dental services are those that are medically necessary and must be carried out in a hospital. Such services include:

- ☐ oral surgery required in hospital as a result of trauma;
- ☐ treatment for infants with cleft palate;
- ☐ hospital-based dental care to support medical/surgical care (e.g., extractions when medically necessary); and
- ☐ surgical treatment for temporomandibular joint dysfunction.

Surgical-dental services can be added to the list of insured services covered under the Medical Services Plan through a process of discussion and consultation with provincial dental surgeons. The Executive Director of the Medical Services Branch manages the process of adding a new service. Although formal public consultations are not held, any member of the public may recommend that surgical-dental services be added to the Medical Services Plan.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Uninsured hospital, physician and surgical-dental services in Saskatchewan include:

- ☐ in-patient and out-patient hospital services provided for reasons other than medical necessity;
- ☐ the extra cost of private and semi-private hospital accommodation not ordered by a physician;
- ☐ physiotherapy and occupational therapy services not provided by or under contract with a District Health Board;
- ☐ services provided by health facilities other than hospitals unless through an agreement with Saskatchewan Health;
- ☐ non-emergency cataract and non-emergency diagnostic imaging services provided outside Saskatchewan without prior written approval;
- ☐ non-emergency insured hospital, physician or surgical-dental services obtained outside Canada without prior written approval;
- ☐ non-medically required elective physician services;

- surgical-dental services that are not medically necessary or are not required to be performed in a hospital; and
- services covered by the Saskatchewan Workers' Compensation Board.

As a matter of policy and principle, insured hospital, physician and surgical-dental services are provided to residents on the basis of assessed clinical need. Compliance is periodically monitored through consultation with District Health Boards, physicians and dentists.

There are no charges allowed in Saskatchewan for medically necessary hospital, physician or surgical-dental services. Charges for enhanced medical services or products are permitted only if the medical service or product is not deemed medically necessary. Compliance is monitored through consultations with District Health Boards, physicians and dentists.

Insured hospital services could be de-insured by the Government if determined no longer medically necessary. The process is based on discussions among District Health Boards, practitioners and officials from the Department of Health.

Insured surgical-dental services could be de-insured if determined not medically necessary or not required to be carried out in a hospital. The process is based on discussion and consultation with the dental surgeons of the Province and managed by the Executive Director of the Medical Services Branch.

Insured physician services could be de-insured if determined not medically required. The process is based on consultations with the Saskatchewan Medical Association and managed by the Executive Director of the Medical Services Branch.

Formal public consultations about de-insuring hospital, physician or surgical-dental services may be held if warranted.

No health services were de-insured in 2001-2002.

3.0 Universality

3.1 Eligibility

The Saskatchewan Medical Care Insurance Act (sections 2 and 12) and The Medical Care Insurance Beneficiary and Administration Regulations define eligibility for insured health services in Saskatchewan. There were no changes to this legislation during 2001-2002.

Eligibility is limited to residents. "Resident" means a person legally entitled to remain in Canada, makes his or her home and is ordinarily present in Saskatchewan, or any other person declared by the Lieutenant Governor in Council to be a resident.

Canadian citizens and permanent residents of Canada relocating from within Canada to Saskatchewan are generally eligible for coverage on the first day of the third month of establishing residency in Saskatchewan.

Returning Canadian citizens, the families of returning members of the Canadian Forces, international students and international workers are eligible for coverage on establishing residency in Saskatchewan, provided that residency is established before the first day of the third month following their admittance to Canada.

The following persons are not eligible for insured health services in Saskatchewan:

- members of the Canadian Forces and the Royal Canadian Mounted Police, federal inmates; refugee claimants; and Kosovar Refugees who are covered under the Interim Federal Health Program;
- visitors to the Province; and
- persons eligible for coverage from their home province or territory for the period of their stay in Saskatchewan (e.g., students and workers covered under temporary absence provisions from their home province or territory).

Such people become eligible for coverage as follows:

- discharged members of the Canadian Forces and the Royal Canadian Mounted Police, if stationed in or resident in Saskatchewan on discharge date;

- released federal inmates;
- refugee claimants, on receipt of Convention Refugee status (immigration documentation is required); and
- Kosovar Refugees, on expiration of their coverage under the Interim Federal Health Program (immigration documentation is required).

3.2 Registration Requirements

The following process is used to issue a health services card and to document that a person is eligible for insured health services:

- every resident other than a dependent child under 18 years is required to register;
- registration should take place immediately following the establishment of residency in Saskatchewan;
- registration can be carried out either in person in Regina or by mail;
- each eligible registrant is issued a plastic health services card bearing the registrant's unique lifetime nine-digit health services number; and
- cards are renewed every three years. (Current cards expire December, 2002.)

All registrations are family-based. Parents and guardians can register dependent children in their family units if they are under 18 years of age. Children 18 and over living in the parental home or on their own must self-register.

The number of persons registered for health services in Saskatchewan on June 30, 2001, was 1,024,788.

3.3 Other Categories of Individual

Other categories of individual who are eligible for insured health service coverage include persons allowed to enter and remain in Canada under authority of either an Employment Authorization, Student Authorization or Minister's Permit issued by Citizenship and Immigration Canada. Their accompanying family may also be eligible for insured health service coverage.

Refugees are eligible on confirmation of Convention status combined with either an employment/student authorization, Minister's permit or permanent resident, i.e., landed immigrant record.

As of June 30, 2001, there were 4,280 such temporary residents in Saskatchewan.

4.0 Portability

4.1 Minimum Waiting Period

In general, insured persons from another province or territory who move to Saskatchewan are eligible on the first day of the third month following establishment of residency. However, where one spouse arrives in advance of the other, the eligibility for the first arriving spouse is established on the earlier of a) the first day of the third month following arrival of the second spouse; or b) the first day of the third month following the establishment of residency by the first spouse.

4.2 Coverage During Temporary Absences in Canada

Section 3 of The Medical Care Insurance Beneficiary and Administration Regulations of *The Medical Care Insurance Act* prescribes the portability of health insurance provided to Saskatchewan residents while temporarily absent within Canada. There were no changes to this legislation in 2001-2002.

Continued coverage during such a period of temporary absence is conditional upon the registrant's intent to return to Saskatchewan residency immediately on expiration of the approved absence period as follows:

- education: for the duration of studies at a recognized education facility (written confirmation by a Registrar of full-time student status is required annually);
- employment: up to 12 months (no documentation required); and
- vacation and travel: up to 12 months.

Section 6.6 of *The Department of Health Act* provides the authority for payment of in-patient hospital services to Saskatchewan beneficiaries temporarily residing outside the Province.

Section 10 of The Saskatchewan Medical Care Insurance Payment Regulations provides for the payment of physician services to Saskatchewan beneficiaries temporarily residing outside the Province.

Saskatchewan has bilateral reciprocal billing agreements with all provinces for hospital services and all but Quebec for physician services. Rates paid are at the host province rates.

In 2001-2002 expenditures for insured out-of-province physician services were $15.52 million. Insured out-of-province hospital services were $27.87 million.

4.3 Coverage During Temporary Absences Outside Canada

Section 3 of The Medical Care Insurance Beneficiary and Administration Regulations of *The Medical Care Insurance Act* describes the portability of health insurance provided to Saskatchewan residents who are temporarily absent from Canada.

Continued coverage for students, temporary workers and vacationers and travellers during a period of temporary absence from Canada is conditional on the registrant's intent to return to Saskatchewan residence immediately on expiration of the approved period as follows:

- students: for the duration of studies at a recognized educational facility (written confirmation by a Registrar of full-time student status is required annually);
- employment of up to 24 months (written confirmation from the employer is required); and
- vacation and travel of up to 12 months.

Section 6.6 of *The Department of Health Act* provides the authority under which a resident is eligible for health coverage when temporarily outside Canada. In summary, a resident is eligible for medically necessary hospital services at the rate of $100 per in-patient and $50 per out-patient visit per day.

In 2001-2002, $1,009,400 was paid for in-patient hospital services and $375,900 was spent on out-patient hospital services.

4.4 Prior Approval Requirement

Out-of-Province

Saskatchewan Health covers most hospital and medical care received by its residents in Canada through a reciprocal billing arrangement. This arrangement means that residents do not need prior approval and may not be billed for most services received in other provinces or territories while travelling within Canada. The cost of travel, meals and accommodation are not covered.

The reciprocal arrangement for physician services applies to every province except Quebec. Physician bills are submitted and Saskatchewan Health pays for insured services provided in Quebec at Saskatchewan rates. However, the physician fees will be paid at Quebec rates with prior approval.

Prior approval is required for the following services provided out-of-province:

- alcohol and drug, mental health and problem gambling services; and
- cataract surgery services, bone densitometry, and Magnetic Resonance Imaging (MRI), since Saskatchewan Health doesn't normally cover these services out-of-province.

Before the Department of Health funds services for a Saskatchewan resident in another province or territory, prior approval from the Department must be obtained by the patient's specialist.

Out-of-Country

Prior approval is required for the following services provided outside Canada:

- If a specialist physician refers a patient outside Canada for treatment not available in Saskatchewan or another province, the referring specialist must seek prior approval from the Medical Services Plan of Saskatchewan Health. Requests for out-of-country cancer treatment must be approved by the Saskatchewan Cancer Agency. If approved, Saskatchewan Health will pay the full cost of treatment, excluding any items that would not be covered in Saskatchewan.

- Saskatchewan Health does not normally cover elective (non-emergency) hospital, physician, optometric, and chiropractic services; therefore, prior approval is required.

5.0 Accessibility

5.1 Access to Insured Health Services

To ensure that access to insured hospital, physician and surgical-dental services is not impeded or precluded by financial barriers, extra-billing by physicians or dental surgeons and user charges by hospitals for insured health services are not allowed in Saskatchewan.

The Saskatchewan Human Rights Code prohibits discrimination in the provision of public services, which include insured health services, on the basis of race, creed, religion, colour, sex, sexual orientation, family status, marital status, disability, age, nationality, ancestry or place of origin.

5.2 Access to Insured Hospital Services

As of March 31, 2002, Saskatchewan had 3,093 staffed hospital beds in 66 acute care hospitals, including 2,544 acute care beds, 209 psychiatric beds and 340 other beds.

The Wascana Rehabilitation Hospital had 118 rehabilitation beds, 109 extended care beds and 80 other long-term care beds. Rehabilitation services are also provided in a Geriatric Rehabilitation Unit in one acute care hospital and in two special care facilities.

The Department does not collect information on acute care beds used for out-patient services.

Province-wide data from the Provincial Health Employer Survey shows that throughout the 1990s, there was small but steady growth in the numbers of health professionals employed in the provincial health system. In almost all cases, the number of practising health professionals in the Province increased throughout the last decade. There were, however, decreases in the number of Registered Nurses (about 6.75 percent), Licensed Practical Nurses (about 21 percent) and Registered Psychiatric Nurses (about 5.3 percent) over this period.

The Canadian Institute for Health Information's Registered Nurses Database indicates that in 2001, the ratio of Registered Nurses to population in Saskatchewan (80.8/10,000) was similar to other provinces and higher than the rate for Canada as a whole (74.3/10,000).

In the past two years, hospitals have experienced shortages of nursing staff, particularly nurses with specialized training to work in areas such as operating rooms, intensive care and dialysis.

Listed below are some of the 2001-2002 initiatives implemented to improve the recruitment and retention of nurses.

- A nursing bursary program of $500,000 was provided for students in LPN, RPN and RN programs.
- A principal nursing advisor for Saskatchewan was appointed to provide advice and expertise to the Minister and Deputy Minister on policy and program issues pertaining to nursing, as well as working with health professionals, employers, professional regulatory bodies and unions to address nursing issues.
- A Provincial Nursing Council was established and in 2001 provided $700,000 in funding for projects related to quality workplaces, casualization and mentoring of students during clinical assignments.
- The Province worked with SRNA and the Nursing Education Program of Saskatchewan to develop expanded education options for the nursing program.
- The Province advertised nationally for nurses, and recently launched a new advertising campaign both in-province and across Canada where we are promoting Saskatchewan as a place to live and work, and publicly recognizing our many health providers.

- A memorandum of understanding was signed with the same partners to develop a Northern Nursing Program in Prince Albert to begin in the fall, 2002.
- The Province provided $37,500 in 2001 to fund the Native Access Program for Nursing in Regina.
- Additional funding of $3 million was announced for retaining, recruiting and training health care providers.

With regard to the availability of selected diagnostic, medical, surgical and treatment equipment and services in facilities providing insured hospital services:

- Magnetic Resonance Imaging (MRI) machines are located in Saskatoon (2) and Regina (1);
- Computed Tomography (CT) scanners are available in Saskatoon (3), Regina (3), Prince Albert (1) and Swift Current/Moose Jaw (1);
- renal dialysis is provided at Saskatoon, Regina, Lloydminster, Prince Albert, Tisdale, Yorkton and Swift Current;
- cancer treatment services are provided by the Saskatchewan Cancer Agency's two cancer clinics, the Saskatoon Cancer Centre and the Allan Blair Cancer Agency in Regina. Last year 4,218 new patients began treatment for cancer and about 47,000 cancer treatments were provided to both new and review patients;
- twenty-two sites (in 18 health districts) are involved in the Community Oncology Program that allows patients to receive chemotherapy and other supports closer to home, while maintaining a close link to expertise at the Cancer Centres in Regina and Saskatoon;
- approximately 71 percent of surgery services are provided in Saskatoon and Regina where there are specialized physicians and staff and the equipment to perform a full range of surgical services. An additional 23 percent is provided in six mid-sized hospitals in Prince Albert, Moose Jaw, Yorkton, Swift Current, North Battleford and Lloydminster, with the remaining surgery performed in smaller hospitals across the Province; and
- Telehealth links have been established to provide residents in a number of rural and remote areas with access to specialist, family physician and other health provider services without having to travel long distances.

A number of measures were taken in 2001-2002 to improve access to insured hospital services.

- Access and use of specialized medical imaging services included MRI, CT and bone mineral density testing has grown steadily in Saskatchewan during 2001-2002. In that year, approximately 13,000 MRI tests were performed, representing an eight percent increase from the previous year; approximately 65,000 CT tests were performed, representing a six percent increase from last year.
- Access to renal dialysis services was improved with the June, 2001, expansion at the Prince Albert satellite from four stations to six. Yorkton also worked on plans for an expansion to their satellite, which occurred in April, 2002.
- On June 30, 2000, the 12 month Northern Telehealth Network (NTN) pilot project was completed. The NTN is a partnership between Saskatchewan Health and six health districts. An external evaluation concluded that the network improved access to services for patients and clients, particularly for child psychiatry and dermatology patients. The number of specialist clinics held in the North has remained stable, which means that the NTN has increased access to specialists without increasing their travel.
- The NTN has proven an effective tool for clinical consultation and continuing education in northern Saskatchewan. Saskatchewan Health will continue to support the network, and in the 2000-2001 fiscal year applied to Health Canada for funding under the Canadian Health Infostructure Partnership Program (CHIPP) to further develop this program in the rest of the Province.
- In summer 2001, Chronic Renal Insufficiency Clinics were established in the Regina and Saskatoon districts. The goals of these clinics are to delay the need for dialysis and to better prepare patients in making their treatment choices - haemodialysis, peritoneal or home dialysis or transplant.

- The Community Oncology Program continues to be active enabling many patients to receive chemotherapy and other supports within their own communities. This program was initially piloted in 1996-1997 with four health districts. Currently, there are 22 fully certified community facilities that are able to provide selective chemotherapy treatments to patients in their own communities.
- The Cancer Agency is responsible for the provincial Screening Program for Breast Cancer. The Screening Program has seven sites around the Province and one mobile mammography unit that travels into communities not served by a stationary site. The Screening Program has the highest participation rate in Canada with more than 36,000 women served annually.
- The development of the Prevention Program for Cervical Cancer was formally announced in 2001-2002. A steering committee, the Advisory Committee for the Prevention Program for Cervical Cancer, is responsible for the design and implementation of an organized cervical cancer screening program for Saskatchewan. The program is expected to take two to three years to develop and will be fully operational in 2004.
- The Provincial Stem Cell Transplant Program continues to grow. In 2001-2002, the Program was expanded to include allogenic transplantation (i.e., infusion of tissue-compatible stem cells from a related donor). The provision of this specialized service ensures that more cancer patients can be effectively treated closer to home, reducing the financial and emotional burden of travelling long distances to receive treatment.
- Saskatchewan Health continues to dedicate considerable time and resources to addressing wait-list issues.
- Saskatchewan Health continued to participate in the Western Canada Waiting List Project along with 19 partner organizations from the four western provinces. The Project worked closely with physicians, the public, regional health authorities and governments to develop and test clinical assessment tools. These tools will help physicians to consistently prioritize patients waiting for total hip or knee replacement, cataract surgery, general surgery, children's mental health services and diagnostic MRI scans. The importance and potential of these tools has been widely recognized and their use by clinicians, health authorities and ministries is being actively considered in all western provinces.
- Preliminary findings and recommendations from the report "Surgical Wait List Management; A Strategy for Saskatchewan" formed the basis of the wait-list strategy outlined in the Government's Health Action Plan released in December, 2001.
- The goal of the wait-list strategy outlined in the new Action Plan is to ensure that patients who are waiting for surgery in Saskatchewan receive the care they need within clinically appropriate timeframes and in a fair and equitable manner.
- In March, 2002, the Saskatchewan Surgical Care Network (SSCN) was established to ensure that a variety of perspectives are applied to the important tasks of assessing and determining how to address surgical access issues across the Province. This newly established committee is an important provincial partnership and includes representatives from heath care professions, health districts, training institutions, government and the public. The SSCN and the involvement of a broad range of stakeholders will be essential to gain consensus and move on the strategy for wait-list management in Saskatchewan as outlined in the Action Plan for Health Care. Further, the SSCN will provide key advice to Saskatchewan Health on the planning and delivery of surgical services in the Province.
- In 2001-2002, the provincial government continued to provide funds to the Province's four largest health districts from the $13 million surgical wait-list fund that was initiated in August, 1999, to address wait-list issues and reduce waiting times for insured services. These funds are used to: purchase additional capital equipment; increase available operating room time; fund staff recruitment, retention and training initiatives; and implement coordination and utilization management initiatives.

5.3 Access to Insured Physician and Dental-Surgical Services

As of March 31, 2002, there were 1,633 physicians licensed to practice in the Province and eligible to participate in the Medical Care Insurance Plan. Of these, 937 (63.1 percent) were family practitioners and 696 (42.6 percent) were specialists. This shift to more specialists compared with previous years is the result of including "foreign certified specialists" within the category previously occupied by only Canadian certified specialists.

As of March 31, 2002, there were approximately 368 practising dentists and dental surgeons located in all major centres in Saskatchewan. Ninety-four provided services insured under the Medical Services Plan.

A number of new or continuing initiatives were underway in 2001-2002 to enhance access to insured physician services and reduce waiting times.

- A Long-term Service Retention Program rewards physicians who work in the Province for 10 or more years.
- Effective July 1, 2001, a specialist emergency room coverage program was established to compensate specialist physicians who made themselves available to provide emergency coverage to acute care facilities.
- A Re-entry Training Program provides two grants annually to rural family physicians wishing to enter specialty training, and requires a return service commitment.
- New Specialist Recruitment and Retention Funding provides funding for new initiatives in addition to the existing funding of the Regina and Saskatoon Health Districts.
- A Physician Recruitment Coordinator is assisting rural districts and physicians in recruiting physicians.
- Rural physicians are supported through an integrated Emergency Room Coverage and Weekend Relief Program that compensates physicians providing emergency room coverage in rural areas, and assists those communities with fewer than three physicians to gain access to other physicians to provide weekend relief.
- The Rural Practice Establishment Grant Program makes grants of $18,000 to Canadian-trained or landed immigrant physicians who establish new practices in rural Saskatchewan for a minimum of 18 months.
- The Medical Resident Bursary Program provides bursaries of $18,000 to three family medicine residents to assist them with medical educational expenses in return for a rural service commitment.
- The Undergraduate Medical Student Bursary Program provides an annual grant of $18,000 to medical students who sign a return service commitment to a rural community.
- The Rural Practice Enhancement Training Program provides income replacement to practising rural physicians and assistance to medical residents wishing to take specialized training in an area of need in rural Saskatchewan. A return service commitment is required.
- The Rural Emergency Continuing Medical Education Program provides funds to rural physicians for certification and re-certification of skills in emergency care and risk management. Approved physicians are required to provide service in rural Saskatchewan after completing an educational program.
- The Resident Weekend Relief Program matches second-year family medicine residents with physicians in larger rural communities who are seeking weekend relief.
- The Saskatchewan Medical Association is funded to provide locum relief to rural physicians through the Locum Service Program while they take vacation, education or other leave.
- Support is provided to initiatives for physicians to use allied health professionals and enhance the integration of medical services with other community-based services through the Alternate Payments and Primary Health Services Program.
- The Northern Medical Services Program is a tripartite endeavour of Saskatchewan Health, Health Canada and the University of Saskatchewan to assist in stabilizing the supply of physicians in northern Saskatchewan.

- The Rural Extended Leave Program supports physicians in rural practice who want to upgrade their skills and knowledge in areas such as anaesthesia, obstetrics and surgery by reimbursing educational costs and foregone practice income for up to six weeks.
- The Rural Travel Assistance Program provides travel assistance to rural physicians participating in educational activities.
- The Northern Telehealth Network provides physicians in remote or isolated areas with access to colleagues, specialty expertise and continuing education.

5.4 Physician Compensation

The process for negotiating compensation agreements for insured services with physicians and dentists is prescribed by Section 48 of *The Saskatchewan Medical Care Insurance Act* as follows:

- a Medical Compensation Review Committee is established within 15 days of either the Saskatchewan Medical Association or the Government providing notice to commence discussion on a new agreement;
- each party shall appoint no more than six representatives to the Committee;
- the objective of the Committee is to prepare an agreement respecting insured services that is satisfactory to both parties;
- in the case that a satisfactory agreement cannot be reached, the matter may be referred to the Medical Compensation Review Board, consisting of an appointee by either party who in turn selects a third member; and
- the Board has the authority to make a binding decision on the parties.

In December, 2000, a new three-year agreement (retroactive to April 1, 2000) was successfully negotiated with the Saskatchewan Medical Association. It provides an increase in the Physician Payment Schedule of three percent in each year of the contract. Similar increases were applied to non fee-for-service physicians. Increased funding was also provided for new items and modernization of the payment schedule.

Section 6 of The Saskatchewan Medical Care Insurance Payment Regulations outlines the obligation of the Minister of Health to make payment for insured services in accordance with the Physician Payment Schedule and the Dental Payment Schedule.

Fee-for-service is the most widely used method of compensating physicians for insured health services in Saskatchewan, although sessional payments, salaries, capitation arrangements and blended methods are also used. Fee-for-service is the only mechanism used to fund dentists for insured surgical-dental services.

5.5 Payments to Hospitals

Saskatchewan adopted a population needs-based funding approach in 1994 and 1995. Through this approach, funding is allocated to each District Health Board on the basis of population characteristics determining service needs. Each District Health Board is given a global budget defined by broad service sector (e.g., institutional acute care hospitals, institutional supportive care, home-based services), and is responsible for allocating funds within that budget to address service needs and priorities identified through its needs assessment processes. Districts may receive additional funds for the provision of specialized hospital programs, (e.g., renal dialysis, specialized medical imaging services and specialized respiratory services) or for the provision of services to residents from other health districts.

Payments to health districts for delivering services are made pursuant to sections 32 and 33 of *The Health Districts Act* (1993). The legislation provides authority for the Minister of Health to make grants to District Health Boards for the purposes of the Act and to enter into agreements with District Health Boards respecting grants made pursuant to the Act or any other matter related to the activities or affairs of a District Health Board.

District funding, including the bulk of funding for insured hospital services, is provided through the needs-based funding approach described above.

Designated funds to address surgical wait-list issues were provided to the four largest health districts in 2000-2001. Each district was asked to outline a maximum expenditure on capital equipment and a plan for allocating equipment, with the remainder of the allocated funds to be spent on operational initiatives to increase surgical capacity and throughput. Districts were required to report all expenditures and changes in service volumes resulting from the additional funding.

District Health Boards provide an annual report on the aggregate financial results of their operations.

6.0 Recognition Given to Federal Transfers

The Government of Saskatchewan publicly acknowledged the federal contributions provided through the Canada Health and Social Transfer in the Department of Health 2001-2002 Annual Report, the 2001-2002 Annual Budget and related budget documents, its 2001-2002 Public Accounts, and the Mid-Year Financial Report. These documents were tabled in the Legislative Assembly and are publicly available to Saskatchewan residents. Federal contributions have also been acknowledged on the Saskatchewan Health website, news releases, issue papers, in speeches and remarks made at various conferences, meetings and public policy forums (see Additional Materials section). Federal assistance was also recognized through a provincial advertising campaign about available health benefits called "It's For Your Benefit". The campaign included a booklet widely distributed throughout Saskatchewan, which prominently credited the federal government for its financial contributions.

7.0 Extended Health Care Services

As of March 31, 2002, the range of extended health care services provided by the provincial government included a prescription drug plan; the Saskatchewan Aids to Independent Living Program, which provides medical equipment and appliances to persons with disabilities; the Supplementary Health Program, which provides non-insured health services to people nominated by Saskatchewan Social Services; the Family Health Benefits Program, which provides non-insured health services primarily to children of low-income working families; a children's dental education program; a hearing aid program; partial coverage for services provided by chiropractors, optometrists and chiropodists; home care services; long-term care services; air and road ambulance services; community clinic and community health centre services; alcohol and drug services; mental health services; occupational and physical therapy.

Nursing Home Intermediate Care Services

- Special-care homes provide institutional long-term care services to meet the needs of individuals with heavy care needs. Services offered include care and accommodation, respite care, day programs, night care, palliative care, and in some instances convalescent care. These facilities are publicly funded through the District Health Boards and are governed by *The Housing and Special-care Homes Act*.
- Public Health Services of District Health Boards provide immunization to residents in long-term care facilities and other similar residential facilities under the provincial immunization program. Saskatchewan Health purchases the vaccines and provides them free of charge to Public Health Services of District Health Boards who then provide them to local long-term care and other similar residential facilities. This applies to influenza and pneumococcal vaccines.

Adult Residential Care Services

Mental Health Services

- Apartment Living Programs and Group Homes provide a continuum of support and living assistance to individuals with long-term mental illnesses and are governed by *The Residential Services Act*.
- Saskatchewan Health, in partnership with the Midwest Health District, offers a rehabilitation program for people and families struggling with eating disorders. BridgePoint Centre delivers this program and is currently governed by *The Non-profit Corporations Act* and *The Co-operatives Act*.

Alcohol and Drug Services

- Alcohol and drug services generally fall under *The Health Districts Act*. Facilities that provide residential alcohol and drug services are licensed as listed below. Saskatchewan Health or the Health Districts contract with community based and non-profit organizations to provide services governed by *The Non-profit Corporations Act*.
- Detoxification services provide a safe and supportive environment in which the client is able to undergo the process of alcohol and other drug withdrawal and stabilization. Accommodation, meals and self-help groups are offered for up to 10 days. *The Housing and Special-care Homes Act* governs detoxification services.
- In-patient services are provided to individuals concerned about their own or others' use of alcohol or drugs. Services offered include assessments, counselling, education and support for up to four weeks or longer depending on individual needs. In-patient services are governed by *The Housing and Special-care Homes Act*.
- Long-term residential services provide services for an extended period to individuals recovering from chemical dependency and addiction. These facilities offer counselling, education and relapse prevention in a safe and supportive environment. *The Housing and Special-care Homes Act* governs long-term residential services.

Home Care Services

- The Home Care Program provides an option for people with varying degrees of short and long-term illness or disabilities to remain in their own homes rather than in a care facility. The Program is designed to provide care and services for individuals with palliative, acute and supportive care needs. Services include assessment/care coordination, nursing, personal care, respite, homemaking, meals, home maintenance, therapy and volunteer services. Individualized funding is a recently announced option of the Home Care Program. This option provides funding directly to people so they can arrange and manage their own supportive services. The Home Care Program is governed by *The Home Care Act* (repealed but not proclaimed at March 31, 2002) and *The Health Districts Act*.

Ambulatory Health Care Services

- Saskatchewan Health Districts provide a full range of mental health and alcohol and drug services in the community. Mental health services are governed by *The Mental Health Services Act*.
- Host Saskatchewan Health Districts offer chiropody services. Services include assessment, consultation and treatment. *The Chiropody Services Act* governs this program.
- Saskatchewan Health Districts also offer a Hearing Aid Program. Services include hearing testing, assessments for at-risk infants, and the selling, fitting and maintenance of hearing aids. *The Hearing Aid Act* and Regulations and *The Health Districts Act* govern these programs.
- Community therapies, including occupational and physical therapies, are offered by the Saskatchewan Health Districts and help individuals of all ages to improve their functional independence. Services are provided in facilities, schools, hospitals, and private homes and include assessment, consultation and treatment. *The Health Districts Act* governs this program.

8.0 Additional Materials Submitted to Health Canada

- Saskatchewan Health Annual Report, 2001-2002
- Healthy People. A Healthy Province. The Action Plan for Saskatchewan Health Care.
- It's For Your Benefit: A Guide to Health Coverage in Saskatchewan.

Alberta

Introduction

The Ministry of Alberta Health and Wellness includes the Department of Health and Wellness (the Department) and the Alberta Alcohol and Drug Abuse Commission (AADAC).

Mission

The mission of the Ministry is to lead and support a system for the delivery of quality health services and to encourage and support healthy living. The vision of the Department is "Citizens of a Healthy Alberta Achieving Optimal Health and Wellness."

In addition to the principles described in the *Canada Health Act*, the Department is committed to providing a health system that:

- ☐ demonstrates excellence. High standards and best practices are achieved through research, education and information;
- ☐ provides for equal access by all Albertans to a comprehensive range of integrated health services;
- ☐ provides quality services and effective outcomes;
- ☐ builds on shared responsibility and decision-making among users and providers;
- ☐ ensures accountability, at all levels, for outcomes; and
- ☐ is cost-effective and sustainable in the long term.

In addition to meeting the requirements specified in the *Canada Health Act*, the Department also provides full or partial coverage for a number of other health care services, such as:

- ☐ home care and long-term care;
- ☐ mental health services;
- ☐ Extended Health Benefits for senior citizens, recipients of the Alberta Widows' Pension (and the eligible dependants of both);
- ☐ palliative care;
- ☐ immunization programs for children; and
- ☐ some allied health services such as optometry (for residents under 19 and over 65 years), chiropractic, and podiatry.

Regional Health Authorities and Provincial Health Authorities

In Alberta, 17 regional health authorities and two provincial health authorities deliver health services. The regional health authorities are responsible for hospitals, continuing care facilities, community health services and public health programs in the Province. They deliver health services in the regions and work with communities to provide health services locally.

During the 2001-2002 fiscal year, the 17 regional health authorities' boundaries were readjusted as part of the establishment of electoral districts for the first-ever regional health authority board member elections.

On October 15, 2001, Albertans elected candidates to serve on the regional health authority boards. Two thirds of the board positions are now filled by election and one third of the board positions are designated appointed positions.

The two provincial health authorities (the Alberta Cancer Board and the Alberta Mental Health Board) provide health services on a province-wide basis.

Regional Health Authority Funding

Beginning with the 1997-1998 fiscal year, Alberta adopted a new method of funding regional health authorities to ensure that each region received its fair share of available health dollars. This funding method is referred to as "Population-Based Funding". Under this method, funds are allocated to each regional health authority according to the population in each region and its estimated relative health care expenditure requirements.

The population's health care expenditure requirements are measured by taking into account:

- the total population base of each region;
- the age and gender of the population base;
- the socio-economic composition of the population base; and
- services provided by regions to residents of other regions.

Province-wide Services Funding

Province-wide services funding is targeted to provide a range of high-cost, high-tech, life-sustaining services that are funded separately from the basic health services covered under population-based funding. Province-wide services planning, delivery and standards setting are collaborative efforts between the Department and the Calgary Health Region and Capital Health Authority. These services are only delivered in Edmonton and/or Calgary. Therefore availability of centrally funded services to all Alberta residents, regardless of where they live, is ensured.

Alberta Health Care Insurance Plan Statistics

In the 2001-2002 fiscal year 5,079[1] physicians and 3,090[1] allied health practitioners were registered with and received payment from the Alberta Health Care Insurance Plan. There were 3,072,384[1] residents registered with the Alberta Health Care Insurance Plan.

The number of practitioners registered with and receiving payment from the Alberta Health Care Insurance Plan as of March 31, 2002, was:

Physicians	5,079[1]
Oral Surgeons/Dentists	1,524[1]
Chiropractors	745[1]
Optometrists	326[1]
Podiatrists	48[1]
Denturists	197[1]
Opticians	250[1]
TOTAL	8,169[1]

In 2001-2002, the Alberta Health Care Insurance Plan issued a total of $1,061,169,693[1] in fee-for-service payments to Alberta physicians and a total of $61,875,778[1] to Alberta allied health practitioners (dental surgeons, dentists, chiropractors, optometrists, podiatrists), for basic health services.

Key Alberta activities in 2001-2002:

- a province-wide meningococcal immunization program (for ages 2 to 24) was launched;
- chickenpox vaccination was added to the infant immunization program;
- the Alberta Health and Wellness base budget was increased for 2001-2002 by 13.5 percent or $737 million, for a total Alberta Health and Wellness budget of $6.271 billion in 2001-2002. Actual Alberta Health and Wellness spending in 2001-2002 was $6.325 billion;
- the *Health Information Act* was proclaimed on April 25, 2001. This Act protects the personal health information of all Albertans;
- the Health Services Utilization Commission was established to gather and provide information on how health services are delivered and used in Alberta;
- in accordance with the amending agreement signed by the Alberta Medical Association and Alberta Health and Wellness, numerous changes were made to the Schedule of Medical Benefits, effective April 1, 2001 and November 1, 2001. These changes included:
    - an increase of 4.38 percent, which was applied to all rates in the Schedule of Medical Benefits, (except for: diagnostic interview and evaluation or consultation – telehealth assistance service; diagnostic interview and evaluation, described as limited – visit not requiring complete

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[1] NOTE: These figures will be considered preliminary until the release of the Alberta Ministry of Health and Wellness' *Alberta Health Care Insurance Plan, Statistical Supplement 2001-2002*.

  history and evaluation, prenatal visit, routine post-natal office examination, repeat office visit – referred cases only; and diagnostic interview and evaluation, described as comprehensive – comprehensive visit, which received a 10.2 percent increase);
  - diagnostic interview and evaluation, unqualified – assessment of an unrelated condition in association with a Workers Compensation service – (paid at $10) was added to the Schedule of Medical Benefits;
  - deletion of obsolete health service codes;
  - rate increases for surcharges, major and minor tray services, surgical assistance modifiers and general anaesthetic modifiers, and
  - a number of new health service codes were added to reflect current practices;
- minor boundary changes were made to six regional health authorities;
- Albertans elected candidates to serve on regional health authority boards;
- the Premier's Advisory Council on Health released a comprehensive report on health reform, *A Framework for Reform*; and
- in response to the Premier's Advisory Council report, the Government launched its action plan on health care reform.

Some of the major challenges facing the Department are:

- labour and drug costs;
- technology and the change in demographics; and
- public expectations and demands for services.

Additional information on Alberta Health and Wellness can be obtained on our web site at

www.health.gov.ab.ca

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The Alberta Health Care Insurance Plan is operated on a non-profit basis and is administered by the Minister of Health and Wellness.

The Alberta Health Care Insurance Plan is governed by the *Alberta Health Care Insurance Act* and Regulations (AR216/81 – declared in force on July 1, 1981). The *Alberta Health Care Insurance Act* was proclaimed in 1969. It provides benefits for basic health services to all Alberta residents, as defined in the *Alberta Health Care Insurance Act*, and extended health services to residents 65 years of age or older, or those who are receiving the Alberta Widows' Pension and their eligible dependants.

- Part 1, section 3 of the *Alberta Health Care Insurance Act* authorizes the operation of the Alberta Health Care Insurance Plan.
- Section 4 describes "coverage under the Alberta Health Care Insurance Plan".
- Section 5 describes payment of benefits and emergency services. Section 5 prohibits extra-billing and identifies "other prohibited fees".

There were no legislative amendments that changed the name or public authority of the Alberta Health Care Insurance Plan in 2001-2002. The Alberta Health Care Insurance Regulation was amended as to coverage during temporary absences. Specifically, the definition of temporary absence was changed to limit temporary absences to 12 months outside Alberta, but inside Canada, and six months outside Canada. The Minister may extend these time periods if the person intends to return to Alberta and there are extenuating circumstances. Amendments were also made to allow for continued coverage for a resident for up to12 months while relocating to another province while the spouse remains in Alberta.

The role and mandate of the Department is:

- to preserve, protect and improve the health of Albertans and the quality of the health system;

☐ to develop health policy and standards and identify resources required to sustain the health system and meet Albertans' health needs on an ongoing basis; and

☐ to ensure that health services are appropriate, well managed and accessible to all Albertans.

1.2 Reporting Relationship

The Alberta Health Care Insurance Plan is administered through the Program Services Division of the Department. The Assistant Deputy Minister of the Program Services Division reports to the Deputy Minister of the Department, who in turn reports to the Minister of Health and Wellness. The Minister is accountable to the Legislative Assembly and the Government of Alberta. In turn, the Government of Alberta is accountable to all Albertans.

The Department issues an Annual Report that contains the Ministry's Accountability Statement, Management Responsibility for Reporting and the consolidated financial statements of the Ministry of Health and Wellness. In addition, the Annual Report provides information about the actions, key achievements and results for all key performance measures included in the 2001-2002 business plan for each of the Department's four goals that support the two core businesses of the Department.

The two core businesses of the Department are:

☐ to lead and support a system for the delivery of quality health services; and

☐ to encourage and support healthy living.

The Department's Annual Report for the year ended March 31, 2002 was prepared under the direction of the Minister of Alberta Health and Wellness in accordance with the *Government Accountability Act* and the Government's accounting policies.

☐ Section I of the Annual Report contains the audited consolidated financial statements of the Department and a comparison of actual performance results to desired results set out in the Ministry's Business Plan.

☐ Section II provides financial statements of the regional health authorities and provincial boards, which are accountable to the Minister of Alberta Health and Wellness.

The Department also issues an annual statistical supplement report on data related to the Alberta Health Care Insurance Plan, primarily the number of people registered and the fee-for-service payments made to Alberta physicians and allied practitioners, i.e., oral and dental surgeons, chiropractors, optometrists and podiatrists. Statistics regarding the Extended Health Benefits (EHB) Program and the Alberta Blue Cross Non-Group coverage offered through the Alberta Health Care Insurance Plan are also provided in this report.

1.3 Audit of Accounts

The Auditor General of Alberta has the mandate to perform attest audits on the accounting records and financial statements of the Minister of Health, including its components – the Department of Health and Wellness and the Alberta Alcohol and Drug Abuse Commission. In addition to the above mentioned attest audit, the Auditor General of Alberta performs specified procedure audits on identified non-financial performance measures and other "systems" audits on these entities. Business plans and annual reports of the Ministry are also reviewed annually.

The attest audits are conducted in accordance with generally accepted auditing standards and results of the audit are based on comparing the audit results with these accounting principles.

Non-financial performance measure audits and system audits are based on standard procedures developed by the Auditor General of Alberta.

The Auditor General of Alberta determines the nature, timing and extent of attest, performance measure and system audits and discusses the audit plan with Health and Wellness officials on an annual basis. Health and Wellness officials are provided the opportunity for input during annual audit planning meetings.

Regional health authorities select auditors to perform audits of their accounting records. Under section 12(1) of the *Regional Health Authorities Act* every regional health authority is required to submit an audited financial statement for the preceding fiscal year. Under section 2(2) of the Regional Health Authorities (Ministerial) Regulation, this statement must be submitted by June 30 of the following year and is included in the annual report of the Ministry as a separate volume.

2.0 Comprehensiveness

2.1 Insured Hospital Services

The *Hospitals Act* (Revised Statutes of Alberta 1980, Chapter H-11 with amendments in force as of December 1, 1997), the Hospitalization Benefits Regulation (AR244/90), the *Health Care Protection Act*, proclaimed September 28, 2000, and Health Care Protection Regulation (which came into force with the *Health Care Protection Act)*, are the legislative authorities that provide for insured services provided in hospitals or designated surgical facilities in Alberta.

No amendments were made to the *Hospitals Act* or the Hospitalization Benefits Regulation in 2001-2002.

The Minister of Alberta Health and Wellness administers the *Hospitals Act*. Regional health authorities are accountable for ensuring the overall management and delivery of all hospital services within their regions. In accordance with the *Hospitals Act* and Regulations, they are required to provide specifically identified "Insured Hospital Services". Services provided beyond Insured Hospital Services are at the discretion of the individual regional health authority.

The *Hospitals Act* defines insured services as "the hospital services the operating costs of which will be provided for under this Part" and goes on to define Standard Ward Hospitalization and where insured services shall be furnished. These services are set out in the Hospitalization Benefits Regulation (AR244/90).

The Hospitalization Benefits Regulation describes "insured services" as follows,

"(a) to in-patients:

> (i) a semi-private or private room, where a patient's medical condition makes it necessary;
>
> (ii) private nursing care for a patient when ordered by the attending physician and approved in accordance with the hospital's by-laws;
>
> (iii) subject to subsection (2)(f) and (g), drugs, biologicals and related preparations when administered in a hospital;
>
> (iv) pacemakers, steel plates, pins, joint prostheses, valve implants and any other goods approved by the Minister;
>
> (v) transportation in Alberta, whether by ambulance or other commercial vehicle to transport a patient in the circumstances described in section 6, i.e., transfer from one hospital to another.
>
> (vi) goods and services included in an approved hospital program or a specific program, but not included in subclauses (i) to (v);
>
> (vii) enhanced goods or services provided under section 5.2(2); [must be a medical necessity as determined by an attending physician],

(b) to out-patients, (i) any medically necessary goods and services that may be provided on an out-patient basis, including goods used in a medical procedure but excluding goods provided to a patient for use after discharge from an approved hospital or facility."

Table 1 identifies the number and types of facilities operating in Alberta in fiscal 2001-2002.

Table 1: Health Care Facilities by Type*

Acute Care Facilities facilities that offer health services provided to persons suffering from serious and sudden health conditions that require ongoing professional nursing care and observation	103[2]
Chronic Care Facilities facilities that offer health services to in-patients who require treatment for long-term or chronic illnesses, diseases or infirmities	106[2]
Rehabilitative Facilities facilities that offer health care services for persons requiring professional assistance to restore physical skills and functionality following an illness or injury	1[2]
Other Community Care Facilities	3[2]
Total	213[2]

* excludes psychiatric hospitals and nursing homes

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[2] NOTE: These figures will be considered preliminary until the release of the Alberta Ministry of Health and Wellness' *Alberta Health Care Insurance Plan, Statistical Supplement 2001-2002*.

Non-hospital surgical facilities, (facilities that offer health care services involving medical operative procedures that do not require an overnight stay in the facility for post-operative recovery or observation – including private cataract/abortion/dental/ophthalmology clinics) and non-hospital diagnostic facilities (facilities that offer health care services for procedures that do not require an overnight stay and that detect or determine various diseases or health conditions) also operate in the Province. These facilities operate under agreements and/or contracts with the regional health authorities. Alberta Health and Wellness collects data only on the insured fee-for-service procedures performed in these facilities and does not collect data on insured hospital services provided within the facilities. According to the College of Physicians and Surgeons of Alberta, there are currently 53 non-hospital day surgical facilities accredited under the College by-laws.

The *Health Care Protection Act* sets out the strongest rules in the country for protecting the publicly funded health system by filling gaps in current legislation, providing protection for the publicly funded and administered health care system, preventing a two-tier system, and providing health authorities with a further option to improve access to services.

Under this Act:

- private hospitals are prohibited from operating;
- surgical facilities are allowed to provide insured surgeries only when they have contracts with a health authority and only when the health authority can demonstrate that there is a net benefit to the public system;
- facility fees for insured surgical services are illegal;
- it is illegal to jump the queue for insured surgeries by paying or receiving money or by purchasing an uninsured surgical service or an enhanced product or service;
- charges for extra medical products and services that are not medically necessary have been limited; and
- patients and the health system are protected from unethical behaviour or conflict-of-interest situations.

Under the *Health Care Protection Act*, non-hospital surgical facilities must:

- be accredited by the College of Physicians and Surgeons to provide the insured surgical services;
- have an agreement for the provision of these insured surgical services with a health authority that has been approved by the Minister; and
- be designated by the Minister to provide these insured surgical services.

In 2001-2002, no amendments were made to either the *Health Care Protection Act* or the Health Care Protection Regulation.

The current process for establishing an approved hospital status (acute care hospitals and auxiliary hospitals) involves departmental review and ministerial approval. For a new hospital this process includes a regional needs assessment; a program and service plan; a hospital functional programming study; identification of functional centres; facility registration and inclusion in the Ministerial Order - "Schedule of Approved Hospitals". Updates to approved hospital status that include amendment to or consolidation of the Ministerial Order - "Schedule of Approved Hospitals" require certification by the health region that all relevant approved hospital data and current common names are accurate and that the approved hospitals are operating in accordance with applicable federal, provincial and departmental legislation and standards.

Publicly owned nursing homes are operated by regional health authorities. Regional health authorities also negotiate and approve contracts for the operation of private or voluntarily owned and operated nursing homes. Under the *Nursing Homes Act* (proclaimed September 1, 1985), Part II, section 6, regional health authorities are responsible for providing the Minister with copies of all nursing home contracts.

Continuing Care Facilities

In Alberta, long-term care facilities are classified as either nursing homes or auxiliary hospitals under current legislation. Collectively these are now referred to as continuing care facilities.

Auxiliary Hospital

Under section 1(1)(c) of the *Hospitals Act*, "auxiliary hospital" means a hospital for the treatment of long-term or chronic illnesses, diseases or infirmities. Auxiliary hospitals are owned by regional health authorities or voluntary, non-profit societies and are operated under the *Hospitals Act* and its Regulations.

Nursing Home

Under section 1(m) of the *Nursing Homes Act*, "nursing home" means a facility for the provision of nursing home care.

Nursing homes are owned by regional health authorities, voluntary societies or private corporations and are operated under the *Nursing Homes Act* and its Regulations. Where a nursing home or auxiliary hospital is owned by a voluntary, non-profit society or private corporation it is operated under a service contract or agreement with the regional health authority.

Continuing care facility operators are responsible for providing all services required under the *Nursing Homes Act* and Regulations and the *Hospitals Act* and Regulations.

These include:

- services provided by auxiliary hospitals and nursing homes such as professional and ancillary nursing care, pharmacy, nutrition, physical therapy services and accommodation services (e.g. laundry, housekeeping, maintenance and administration);
- trust account services;
- supplies for recreation programs;
- medications or drugs and related preparations as prescribed by the attending physician, including oxygen;
- all dressing and wound-care supplies;
- incontinence products and bladder care equipment;
- transportation, including ambulance transport, for prescribed services;
- nutritional supplements as prescribed by the attending physician;
- basic room furniture; and
- special care items such as handrails, sheepskin pads, elbow and ankle protectors, pressure mattresses, side-rail pads, etc.

Section 25(1)(h) of the *Health Care Protection Act* gives the Lieutenant Governor in Council the authority to prescribe whether a particular medical good or service is or is not a standard or an enhanced good or service. The Health Care Protection Regulation sets out major surgical services, minor surgical procedures and standard and enhanced medical goods and services. Adding or removing an item from the Health Care Protection Regulation requires an amendment to the Regulation and the requirements of the Government's regulatory review process must be followed. Routine decisions regarding equipment and supplies used in procedures are the purview of the health authorities and practitioners and are excluded from this process.

The Department is developing a process to define standard and enhanced medical goods and services that will be used on an exception basis to examine medical goods and services that cannot be dealt with by a single health authority, or where an inconsistency in benefits has been identified across regions.

2.2 Insured Physician Services

The Medical Benefits Regulation (AR173/93 effective April 1, 1993), governs the services for which benefits are payable, as well as the requirements for submission of fee-for-service claims to the Alberta Health Care Insurance Plan. This Regulation sets the rates for benefits as those "set out in the Schedule of Medical Benefits prepared and published by the Department and approved by the Minister."

There were no amendments to the legislation or Regulations in 2001-2002 with regard to insured physician services.

The *Alberta Health Care Insurance Act* defines "physician" as:

- "With reference to medical services provided in Alberta, a person registered as a medical practitioner or as an osteopathic practitioner under the *Medical Profession Act*, and

- With reference to medical services provided in a place outside Alberta, a person lawfully entitled to practise medicine or osteopathy in that place."

The *Alberta Health Care Insurance Act* defines "practitioner" as:

- "A chiropractor, dental mechanic, dental surgeon, optician, optometrist, physician or podiatrist or other person who provides a basic health service or an extended health service."

The *Medical Profession Act* defines "registered practitioner" as:

- "A person registered in the Alberta Medical Register or who is temporarily registered under section 28."

As of March 31, 2002, there were 5,079[3] physicians who were registered with and received payment from the Alberta Health Care Insurance Plan.

Requirements for Physicians and Practitioners

Only those who meet the above requirements are allowed to provide insured physician services under the Alberta Health Care Insurance Plan.

Medical practitioners' offices must be registered by the Department. Practitioners must see patients at the location, book appointments from the location and maintain patient files at the location in order to be registered by the Department.

The *Health Professions Act* (assented to May 9, 1999) establishes consistent regulatory rules for all health professions in Alberta. Once all Regulations are approved, this Act will govern 30 health professions through 28 regulatory colleges. Regulations for dentists and medical laboratory technicians have been proclaimed under the *Health Professions Act*. Regulations for the following professions are expected to be approved in 2002-2003: dieticians, denturists, hearing aid practitioners, licensed practical nurses, opticians, optometrists, social workers, and speech language pathologists and audiologists.

Prior to being registered with the Department, a practitioner must complete the appropriate registration forms and include a copy of his/her licence issued by the appropriate governing body or association – e.g., the College of Physicians and Surgeons of Alberta, the Alberta Dental Association, etc.

Physicians Opting out of the Alberta Health Care Insurance Plan

In accordance with section 5.11(1) of the *Alberta Health Care Insurance Act*, every physician is deemed to have opted into the Alberta Health Care Insurance Plan.

A physician may practise and bill patients for services outside of the Alberta Health Care Insurance Plan. A physician who decides to opt out of the Alberta Health Care Insurance Plan must meet certain conditions at least 180 days prior to the effective date of the opting out.

These conditions include:

- notifying the Minister, in writing, of the intention to opt out, indicating effective date of the opting out;
- publishing a notice of the proposed opting out in a newspaper having general circulation in the area in which the physician practises; and
- posting a notice of the proposed opting out in a part of the physician's office to which patients have access.

As of March 31, 2002, no medical practitioners had opted out.

Schedule of Medical Benefits

The Medical Benefits Regulation (AR 173/93 effective April 1, 1993) describes the services for which benefits are payable. These services are set out in the Schedule of Medical Benefits.

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[3] NOTE: This figure will be considered preliminary until the release of the Alberta Ministry of Health and Wellness' *Alberta Health Care Insurance Plan, Statistical Supplement 2001-2002*.

prepared and published by the Department and approved by the Minister. Specifically, they are:

- general medical services;
- general medical and surgical procedures;
- anaesthesia;
- laboratory medicine and pathology;
- obstetrics;
- gynaecology;
- cardio-thoracic and vascular surgery;
- general surgery;
- orthopaedic surgery;
- neurosurgery;
- urologic surgery;
- otolaryngology;
- ophthalmology;
- reconstructive plastic surgery;
- medicine;
- psychiatry;
- paediatrics;
- dermatology;
- physical medicine and rehabilitation;
- emergency medicine;
- diagnostic radiology;
- therapeutic radiology; and
- neurology.

Alberta also covers unlisted services that the attending physician deems medically required and not experimental or applied research.

Insured physician services and any subsequent additions, deletions or amendments to the Schedule of Medical Benefits are discussed between the Department and the Alberta Medical Association through a subcommittee composed of Alberta Health and Wellness and Alberta Medical Association members. The subcommittee subsequently reports to a joint committee called the Finance Committee. Once approved by the Finance Committee, Deputy Minister/Minister approval is obtained. All changes to the Schedule of Medical Benefits require ministerial approval.

During the period April 1, 2001 to March 31, 2002, the following services were added to the list of insured physician services covered by the Alberta Health Care Insurance Plan:

- assessment of unrelated condition in association with a Workers' Compensation service;
- teleophthalmology consultation for examination, evaluation and interpretation of stereoscopic digital retinal imaging using store and forward technology – benefit includes written recommendation to the primary care physician for follow up and management;
- loop electrical excision procedure (LEEP) – for cervical interepithelial neoplasia;
-ilioplasty, bone graft to iliac crest following harvesting of bone for neurospinal surgery – may not be claimed when bovine xenograft or methylate used;
- comprehensive visit in emergency department, weekdays, 0700-1700 hours;
- comprehensive visit in emergency department, weekdays, 1700-2200 hours or on Saturday, Sunday or statutory holiday, 0700-2200 hours;
- comprehensive visit in emergency department, 2200-0700 hours – NOTE: the three above comprehensive visits may only be claimed by emergency medicine physicians, full-time emergency room physicians, general practitioners or paediatricians working a rotation duty shift in an emergency department with 24 hour on-site coverage AND may also be claimed for those patients whose illness or injury requires prolonged observation, continuous therapy and multiple reassessments as described in General Rule 4.2.7;
- prolonged paediatric consultation, per 15 minutes, which may only be claimed for services other than those described under 03.08G AND may be claimed in addition to 03.08A only when the consultation exceeds 30 minutes; may only be claimed by general practice physicians, generalists in mental health, paediatricians, psychiatrists and specialists in mental health, is to be claimed using the Personal Health Number of the patient, naming the personnel, agencies or

organizations involved AND may be claimed when the physician most responsible for the patient's care has submitted a claim under 08.19F;

- second and subsequent physician attendance at formal, scheduled, professional interview on behalf of a specific psychiatric patient, per 15 minutes may only be claimed by a psychiatrist;
- second physician attendance at group psychotherapy, where all members of the group are receiving therapy in the session, per 15 minutes;
- stentless aortic valve replacement;
- valve conduit repair or replacement of aortic valve and ascending aorta with reimplantation of the coronary arteries. Associated with ruptured aortic aneurysm or aortic dissection;
- remodelling of outflow tract to left ventricle. For asymmetric spetal hypertrophy;
- aortocoronary bypass of one coronary artery without cardiopulomonary bypass;
- aortocoronary bypass of two coronary arteries without cardiopulmonary bypass;
- aortocoronary bypass of three coronary arteries without cardiopulmonary bypass;
- aortocoronary bypass of four coronary arteries without cardiopulmonary bypass;
- aortocoronary bypass of five coronary arteries without cardiopulmonary bypass;
- aortocoronary bypass of six coronary arteries without cardiopulmonary bypass;
- aortocoronary bypass of seven coronary arteries without cardiopulmonary bypass;
- cardiotomy with infarctectomy and reconstruction of ventricular well. For post-infraction, ventricular rupture or repair of ventricular septal defect;
- removal of arterial tumor or other lesion within or on the left or right atrium;
- removal of ventricular tumor with reconstruction of ventricular wall;
- implantation of left or right ventricular assist device, permanent;
- insertion of AV sequential pacemaker, 2 lead;
- insertion of AV sequential pacemaker, 3 lead;
- insertion of AV sequential pacemaker, 4 lead;
- implantation of automatic internal cardioverter defibrillator with left ventricular lead;
- replacement of automatic internal cardioverter defibrillator battery;
- removal of endocardial electrodes, laser assisted;
- removal of pacemaker from site other than new implant site;
- removal of automatic internal cardioverter defibrillator from site other than new implant site;
- carotid endarterectomy with patch repair;
- replacement of aortic arch. For ruptured aneurysm, aortic dissection or traumatic injury;
- resection or repair or thoracic aortic aneurysm. For ruptured aneurysm, dissection or traumatic injury; and
- surgical treatment of ectopic pregnancy.

2.3 Insured Surgical-Dental Services

Under the Alberta Health Care Insurance Plan, the Province insures a number of medically necessary oral surgical procedures that are listed in the Schedule of Oral and Maxillofacial Surgery Benefits. A dentist or dental surgeon may perform a small number of these procedures, but the majority of the procedures can be billed to the Alberta Health Care Insurance Plan only when performed by an oral and maxillofacial surgeon.

Dentists (or dental surgeons) must be registered as members of the Alberta Dental Association or must be entitled to practise dental surgery in any place outside Alberta. Oral and maxillofacial surgeons must be dental specialists in oral and maxillofacial surgery, registered as members of the Alberta Dental Association, or be lawfully entitled to practise oral and maxillofacial surgery in any place outside Alberta.

As of March 31, 2002, there were 250[*] oral surgeons and dentists registered with the Alberta Health Care Insurance Plan, who billed the Alberta Health Care Insurance Plan for insured dental services.

Provisions of opting in and out of the Alberta Health Care Insurance Plan by dentists are set out in section 5.1(1) of the *Alberta Health Care Insurance Act*. Subject to this section, every dentist is deemed to have opted into the Alberta Health Care Insurance Plan.

A dentist may practice and bill patients for services outside the Alberta Health Care Insurance Plan. A dentist who decides to opt out of the Alberta Health Care Insurance Plan must meet certain conditions, at least 180 days prior to the effective date of the opting out. These include:

- notifying the Minister, in writing, of his/her intention to opt out, indicating the effective date of the opting out;
- publishing a notice of the proposed opting out in a newspaper having general circulation in the area in which the dentist practices; and
- posting a notice of the proposed opting out in a part of the dentist's office to which patients have access.

As of March 31, 2002, no dentists or oral surgeons in Alberta had opted out.

The following procedures are insured under the Alberta Health Care Insurance Plan and are listed in the Oral and Facial Surgery Benefits Regulation. Decisions as to whether the procedure is medically necessary, and where it should be performed are left to the surgeon and depend on the medical needs of the patient:

- diagnostic interview and evaluation or consultation;
- arthroscopy temporo-mandibular joint;
- injection or infusion of other therapeutic or prophylactic substance;
- cranioplasty;
- operations on cranial peripheral nerves;
- submucous resection of nasal septum;
- reduction of nasal fracture; intranasal antrotomy;
- repair and plastic operation of nasal sinus;
- excision of dental lesion of jaw; other orthodontic operation;
- repair and plastic operations on tongue;
- other operations on tongue;
- incision of salivary gland or duct;
- excision of lesion of salivary gland;
- other operations on salivary gland or duct; drainage of face or floor of mouth;
- incision of palate;
- excision of lesion or tissue of palate; plastic repair of mouth (internal);
- palatoplasty;
- invasive diagnostic procedures on oral cavity;
- other operations on mouth and face;
- plastic operation on pharynx;
- control of hemorrhage, not otherwise specified;
- reduction of facial fractures;
- incision of facial bone without division;
- temporomandibular arthroplasty;
- other facial bone repair and osteoplasty;
- invasive diagnostic procedures on facial bones;
- other operations on facial bones and joints;
- sequestrectomy;
- synovectomy;
- repair and plastic operations on joint structures;
- incision of muscle, tendon, fascia and bursa;
- relaxation of scar or contracture of skin;
- flap or pedicle graft; and
- oral and burn appliances.

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[*] NOTE: This figure will be considered preliminary until the release of the Alberta Ministry of Health and Wellness *Alberta Health Care Insurance Plan, Statistical Supplement 2001-2002*.

In 2001-2002, a number of oral surgical schedule rate changes were made to the Schedule of Oral and Maxillofacial Surgery Benefits. As well, a number of services were added to the schedule including:

- ❑ new visit codes that may be claimed by all dentists;
- ❑ new visit and procedure codes that may be claimed by oral surgeons and oral pathologists only;
- ❑ new procedure codes that may be claimed by oral surgeons only;
- ❑ a new surgical assist code for oral surgeons to use when assisting physicians; and
- ❑ new modifiers were also added to the schedule that allow oral surgeons and oral pathologists to claim benefits for emergency hospital admission and follow-up hospital visits; surcharge benefits to be claimed for a number of health services.

Also:

- ❑ the General Rules were revised to update and clarify current rules and incorporate new rules in relation to new items; and
- ❑ a number of existing health service codes were amended.

The Claims Branch in the Program Services Division of the Department manages any addition of new surgical-dental items to the list of insured services. Changes to the schedule require ministerial approval. All changes (both addition and deletion of items) are done through extensive consultation with the Department, the Alberta Dental Association and the Oral Maxillofacial Surgery section of the Alberta Dental Association. Depending on the changes, the regional health authorities may also be consulted.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Section 4(2) of the Hospitalization Benefits Regulation provides a listing of uninsured hospital services. The Regulation is detailed in the section entitled Additional Materials Submitted to Health Canada, which appears at the end of this narrative. Services required for the use of third parties, services covered under another provincial/territorial/federal statute, services that have been deemed unnecessary for the patient (i.e., enhanced goods and services), laboratory and x-ray services, drugs, biologicals and related preparations (in some circumstances), and services provided by a facility outside Canada without the prior approval of the Minister, are the types of uninsured services listed in the Hospitalization Benefits Regulation.

Hospital services are provided, in accordance with the *Hospitals Act*, the Hospitalization Benefits Regulation and the *Health Care Protection Act*, by the regional health authorities. Any changes to hospital services provided are at the discretion of the regional health authorities, however, Alberta Health and Wellness does provide regional health authorities with clarification and direction as to what must be covered (i.e. in 2000-2001, Alberta Health and Wellness issued a directive stating that the cost of foldable lenses must be covered).

Ultimately, the Minister of Health is responsible for determining services covered by the Alberta Health Care Insurance Plan. In reviewing whether new medical products, services, or devices should be publicly funded, the Department's process is first to review the scientific literature and seek expert advice as to the safety and effectiveness of the product and next to assess the policy, funding, training and other implications of providing public coverage. Issues requiring immediate attention are addressed on an issues management basis with the most appropriate branch taking the lead.

The *Health Care Protection Act* (section 5) and Regulations specify the conditions that apply when patients are charged for enhanced medical goods and services related to the provision of an insured surgical service. These provisions of the legislation apply to both public hospitals and non-hospital surgical facilities. The legislation limits charges to those enhanced medical goods or services that are listed in Schedule 2 of the Regulation. Currently, there is only one enhanced medical good listed: multi-focal intraocular lens implants. The legislation also specifies the method for determining the amount that may be charged for an enhanced medical good or service. As well, it includes disclosure provisions that apply when an enhanced medical good or service is offered to a patient, i.e., patients must be advised that the standard medical good or service meets generally accepted medical practise and is available at no charge. These are only some of the key provisions relating to the sale of goods and services.

Section 21 of the Alberta Health Care Insurance Regulations sets out services that are not basic health or extended health services and therefore are not considered insured. The Regulation is detailed in the section entitled Additional Materials Submitted to Health Canada, which appears at the end of this narrative. Briefly, some of the services not considered insured under this Regulation are those provided for third parties, (insurance companies, medico-legal services, etc.); advice by telephone or other means of telecommunication, (including toll charges for same); transportation costs (includes costs of both patients and practitioners as well as ambulance costs, unless otherwise directed by the Minister); services covered under another provincial/territorial/federal statute; group immunizations; and services provided by a practitioner to immediate family, except where the Minister rules otherwise.

The Schedule of Oral and Maxillofacial Surgery Benefits details services not insured under that Schedule. The Schedule is detailed in the section entitled Additional Materials Submitted to Health Canada that appears at the end of this narrative. Some of these items are: services that are cosmetic in nature; drugs/medication; advice by telephone (except where the Minister rules otherwise); ambulance services; services that are not medically required; travel time, etc.

Regional Health Authority Responsibilities

Section 5 (Responsibilities of Authority) of the *Regional Health Authorities Act* states "Subject to this Act and the Regulations, a regional health authority shall: (i) promote and protect the health of the population in the health region and work towards the prevention of disease and injury, (ii) assess, on an ongoing basis, the health needs of the health region, (iii) determine priorities in the provision of health services in the health region and allocate resources accordingly, (iv) ensure that reasonable access to quality health services is provided in and through the health region, and (v) promote the provision of health services in a manner that is responsive to the needs of individuals and communities and supports the integration of services and facilities in the health region". Regional health authorities are responsible for ensuring that decisions related to access to insured hospital and other community health services are based on need.

Billing Outside the Alberta Health Care Insurance Plan

In accordance with section 31.1(1) of the Alberta Health Care Insurance Regulations, no person may charge a fee (a) the payment of which is a condition of receiving an insured service provided by a physician who is enrolled in the Alberta Health Care Insurance Plan or a dental surgeon who has opted into the Alberta Health Care Insurance Plan, and (b) that is in addition to the benefit payable by the Minister for the insured service.

In accordance with the *Canada Health Act*, the Alberta Health Care Insurance Plan covers the medically required services physicians provide to patients. When a service is not medically required, physicians may bill a patient for that service. The Department does not regulate physicians' billings for uninsured services. The College of Physicians and Surgeons of Alberta has developed and enforces a policy on this issue entitled *Charging for Uninsured Services*, and the Alberta Medical Association provides the *Guide to Direct Billing for Uninsured Services* to physicians.

The Alberta Health and Wellness/Alberta Medical Association agreement defines de-insurance as "...in respect of an insured service, the decision of the Minister that such insured service is no longer an insured service and no longer payable under the Plan." According to this agreement, Alberta Health and Wellness must notify the Alberta Medical Association of any proposal to de-insure, and the proposal must be discussed by the Finance Committee, the joint Alberta Health and Wellness/Alberta Medical Association body that manages the Agreement. If the Alberta Medical Association does not agree to de-insure the service, Alberta Health and Wellness must wait three months from the notification date to remove the service from the Schedule of Medical Benefits.

There were no medical services de-insured or de-listed in 2001-2002.

Before items are de-insured (deleted) from the Schedule of Oral and Maxillofacial Surgery Benefits, Alberta Health and Wellness consults with the Alberta Dental Association.

In 2001-2002, at the request of the Alberta Dental Association, the following services were removed from the Schedule of Oral and Maxillofacial Surgery Benefits, as they were obsolete/outdated:

- ☐ open reduction of nasal fracture (sinusal approach);
- ☐ removal of an interosseous bone plate by a different surgeon;
- ☐ removal of an interosseous wire or bone plate by the same surgeon;
- ☐ other plastic repair of palate (Surgical rapid palatal expansion);
- ☐ (closed) reduction of other facial fracture (Craniofacial disjunction);
- ☐ other incision of facial bone without division (Oblique osteotomy of ramus – extraoral) including bone graft;
- ☐ other incision of facial bone without division (Sagittal split osteotomy – extraoral);
- ☐ other incision of facial bone without division (Le Fort I advancement);
- ☐ other incision of facial bone without division (Le Fort I intrusion);
- ☐ other incision of facial bone without division (Le Fort I extrusion);
- ☐ other incision of facial bone without division (mid-palatal split – complete);
- ☐ other incision of facial bone without division (anterior segmental osteotomy of the mandible) with transfer of mental eminence; and
- ☐ other incision of facial bone without division (anterior segmental osteotomy of the mandible) without transfer of mental eminence.

3.0 Universality

3.1 Eligibility

Sections 3(1) and 4(3) of the *Alberta Health Care Insurance Act;* sections 4(1), 4(2), 4.1 and 4.2 of the Alberta Health Care Insurance Regulations, section 18.2 of the *Health Insurance Premiums Act*, and section 21 of the Health Insurance Premiums Regulation define eligibility for the Alberta Health Care Insurance Plan.

All Alberta residents are eligible to receive services under the Alberta Health Care Insurance Plan. A resident is defined as a person lawfully entitled to be or to remain in Canada who makes his/her home and is ordinarily present in Alberta and any other person deemed by the Regulations to be a resident, but does not include a tourist, transient or visitor to Alberta.

Persons from outside Canada who move to Alberta to establish permanent residence are eligible for coverage if they are landed immigrants, returning landed immigrants or returning Canadian citizens. All new landed immigrants must provide a copy of their Record of Landing. Temporary residents arriving from outside Canada, who may be deemed residents, include persons on Visitor Records, Student or Employment Authorizations and Minister's Permits.

In each case, copies of the individual's Canada entry document must be reviewed before eligibility for coverage can be determined. A person must have permission to stay in Canada for at least 12 months and intend to spend that time in Alberta to be eligible.

Refugee claimants who entered Canada before January 1, 1989, and who intended to reside in Alberta for 12 months were also eligible for coverage. Refugee claimants who entered Canada after January 1, 1989, are not eligible for coverage until they are deemed Convention Refugees.

Persons moving permanently to Alberta from another country are eligible for coverage on their date of arrival, provided all Canada entry documents are in order and they register within three months of arrival. Persons moving permanently to Alberta from another part of Canada are eligible for coverage on the first day of the third month following arrival, provided they register within three months.

There were no amendments made to this legislation, or the Regulations in 2001-2002.

Residents not eligible for coverage under the Alberta Health Care Insurance Plan are:

- ☐ members of the Canadian Forces;
- ☐ members of the Royal Canadian Mounted Police (RCMP) who are appointed to a rank; and
- ☐ persons serving a term in a federal penitentiary.

However, their family members are eligible for coverage.

Alberta residents who cease to be members of the Canadian Forces, the RCMP, or inmates of federal penitentiaries who are released in Alberta are eligible for coverage on the day of their release.

3.2 Registration Requirements

All new Alberta residents, except those specifically exempt, are required to register themselves and their eligible dependants with the Alberta Health Care Insurance Plan by completing an application. New residents to Alberta should apply for coverage within three months of arrival. If the application is not received within the required time, the effective date is determined at the time of registration. Following registration, the account holder and dependants, if any, are each given a personal health number and card which are used to obtain health services.

Family members are registered on the same account for billing purposes and to ensure that benefits (e.g., extended health benefits non-group Blue Cross) can be provided to all members of the family unit.

In most cases, dependants are defined as a husband and wife and children under 21 years of age who are single and wholly dependent on the parent(s). Dependants can also be:

- ☐ adopted children, foster children and wards for whom the resident is entitled to claim income tax deductions;
- ☐ single children over 21 who are wholly dependant because of physical or mental disabilities;
- ☐ single children under 25 who are full-time students at an accredited educational institution; and
- ☐ separated or common-law spouses, who may also choose to pay premiums independently.

As of March 31, 2002, there were 3,072,384[5] residents registered with the Alberta Health Care Insurance Plan.

Residents who object to the Alberta Health Care Insurance Plan may opt out at the beginning of each benefit period. A benefit period begins July 1 of one year and ends June 30 of the following year. A Declaration of Election to Opt Out must be completed and filed with the Alberta Health Care Insurance Plan by June 30 of each year and premiums must be fully paid to June 30 of the current year. New account holders can opt out at the time of registration or reinstatement. The opt-out period begins the day coverage would have become effective. To remain opted out, a Declaration of Election to Opt Out must be completed and filed with the Alberta Health Care Insurance Plan by June 30 of each year.

During the benefit period July 1, 2001, to June 30, 2002, 295 individuals opted out of the Alberta Health Care Insurance Plan.

3.3 Other Categories of Individual

Temporary residents from outside Canada who may be deemed residents include persons on Visitor Records, Student or Employment Authorizations and Minister's Permits. In each case, copies of the individual's Canada entry document must be reviewed before eligibility for coverage can be determined. A person must have permission to stay in Canada for at least 12 months and intend to spend that time in Alberta. Refugee claimants who entered Canada before January 1, 1989, and who intend to reside in Alberta for 12 months were also eligible for coverage. Refugee claimants who entered Canada after January 1, 1989, are not eligible for coverage until they are deemed Convention Refugees.

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[5] NOTE: This figure will be considered preliminary until the release of the Alberta Ministry of Health and Wellness' *Alberta Health Care Insurance Plan, Statistical Supplement 2001-2002.*

The following figures show the estimated number of individuals residing in Alberta who were covered under the above conditions on March 31, 2002:

Minister's Permit	166[6]
Student Authorization	5,879[6]
Visitor's Record	3,453[6]
Employment Authorization	5,792[6]

3.4 Premiums

All residents of Alberta, except dependants and individuals excluded from registration, are required to pay premiums. The current monthly premium rates are $34 for single coverage and $68 for family coverage (two or more people). Individuals enrolled in special groups, such as Alberta Widows' Pension and Support for Independence, are exempt from paying premiums. There are two programs available to assist lower- income, non-senior Albertans with the cost of their premiums: the Premium Subsidy Program and the Waiver of Premiums Program. Seniors are required to pay premiums at the same rates as non-seniors. Seniors' eligibility for premium assistance is determined through the Alberta Seniors Benefit Program.

Although Albertans are required to pay premiums, no resident is denied coverage due to an inability to do so.

4.0 Portability

4.1 Minimum Waiting Period

Persons moving permanently to Alberta from another part of Canada are eligible for coverage on the first day of the third month following their arrival, provided they register within three months of arrival.

4.2 Coverage During Temporary Absences in Canada

Sections 5(1) and 5(3) of the *Alberta Health Care Insurance Act* and section 1(2) of the Alberta Health Care Insurance Regulations define portability of health insurance during temporary absences in Canada.

Residents leaving Alberta for another part of Canada for 12 months or less must maintain their Alberta Health Care Insurance Plan coverage during their absence. If the absence will be longer than 12 months, coverage may be cancelled or residents have the option of applying for extensions. These extensions are:

- ☐ extended visits or vacations, to a maximum of 24 consecutive months from date of departure. Extensions must be requested in person, by phone or in writing;
- ☐ employment or business engagements, to a maximum of 48 consecutive months from date of departure. A letter from the employer confirming the length of the business contract is required;
- ☐ full-time students at an accredited educational institute are provided coverage until their educational training is complete. After the first year, verification of full-time student status must be submitted yearly to maintain coverage;
- ☐ sabbatical leave or educational leave from employment for advanced training, to a maximum of 24 consecutive months from date of departure. A letter from the employer confirming their training and length of absence is required;

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[6] NOTE: These figures will be considered preliminary until the release of the Alberta Ministry of Health and Wellness' *Alberta Health Care Insurance Plan, Statistical Supplement 2001-2002.*

- ☐ missionary work for an approved registered organization, to a maximum of 48 consecutive months from the date of departure. A letter from the religious organization confirming date of departure, destination and length of absence is required. Missionaries may return to Alberta on furlough (leave of absence or vacation) from their duties. The period of time they are in Alberta is counted as part of their temporary absence and does not indicate they have re-established permanent residence.

There were no amendments made to this legislation or the Regulations in 2001-2002.

Hospital Reciprocal Agreement

Alberta participates in the Hospital Reciprocal Agreement with the Provinces and territories, which allows for the processing of hospital costs provided to Albertans and non-Albertans by the host province. Claims are paid at the standard ward rate for in-province insured services approved by each provincial or territorial jurisdiction and at out-patient rates for insured services approved by the Co-ordinating Committee on Reciprocal Billing. Exchange of claims data between each jurisdiction takes place on a monthly basis.

Medical Reciprocal Agreement

Alberta also participates in the Medical Reciprocal Billing Agreement with provinces and territories, except Quebec. The Agreement allows for the processing of medical costs provided to Albertans and non-Albertans by the host province. Claims are paid in accordance with the rates, rules and Regulations of the host provinces' physician's fee schedule for insured medical services. Exchange of claims data between the provincial/ territorial jurisdictions takes place monthly.

Services excluded from both the Hospital and Medical Reciprocal Agreement billing processes, such as abortions, must be billed directly by the physician to the patient or to the patient's home province/territory for payment consideration.

The Capital Health Authority has also entered into agreements with the Northwest Territories and Nunavut that allow for Northwest Territories and Nunavut patients to be treated within the region's hospitals and be paid at an agreed in-patient rate. The billing process for these claims is similar to the in-patient hospital reciprocal billing arrangement between the Provinces and territories. Services excluded from reciprocal billing are also excluded from these agreements.

Payment for insured hospital and medical services provided to eligible Albertans elsewhere in Canada is at the rate approved by the hospital insurance plan of the Province or territory in which the goods or services are provided, unless the Minister has entered into an agreement with the government of a province or territory to apportion the costs in a different manner.

Payment for insured medical services provided to eligible Albertans elsewhere in Canada are at the host provincial or territorial rates, including Quebec.

In 2001-2002, the total amount paid for in- and out-patient insured hospital services provided to Alberta residents out-of-province (within Canada) was $19,443,370[7].

4.3 Coverage During Temporary Absences Outside Canada

Sections 5(1) and 5(3) of the *Alberta Health Care Insurance Act* and section 1(2) of the Alberta Health Care Insurance Regulation define portability of health insurance during temporary absences outside Canada.

Alberta residents leaving Canada for six months or less must maintain their Alberta Health Care Insurance Plan coverage during their absence. If the absence will be longer than six months, coverage can be cancelled or residents have the option of applying for extensions. These extensions are the same as for those temporarily absent within Canada (please see details in section 4.2 for a description).

Hospital benefits are payable only when services are provided in acute care facilities that provide standard services such as intensive care units or emergency wards, or auxiliary hospitals that provide standard acute care services to long-term or chronically ill patients. If services are not insured in the Province, they are not insured when provided outside the country. The maximum amount payable for out-of-country in-patient hospital services is $100 (Canadian) per day, not including day of discharge. The maximum hospital out-patient per visit rate is $50 (Canadian), with a limit of one visit per day. The only exception to the out-patient per visit rate is haemodialysis which is paid at a maximum of $220 per visit, or the amount charged, whichever is less, also with a limit of one visit per day.

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[7] NOTE: This figure will be considered preliminary until the release of the Alberta Ministry of Health and Wellness' *Alberta Health Care Insurance Plan, Statistical Supplement 2001-2002.*

Benefits for out-of-country practitioner services are payable according to the fee charged or the Alberta rate, whichever is the lesser.

Full coverage for treatment costs outside of Canada may be provided under the following two programs:

- ☐ the Out-of-Country Health Services OOCHS) Program, which may apply where the required service is not available in Canada; and
- ☐ the Emergency Financial Assistance Program, which may apply where the treatment expense was received due to an emergency, was in excess of benefits covered by the Alberta Health Care Insurance Plan and payments prescribed in the Regulations under the *Hospitals Act* could not reasonably be foreseen and guarded against; and would place an undue burden on the financial resources of the resident.[8]

There were no amendments to this legislation or the Regulations in 2001-2002.

4.4 Prior Approval Requirement

Prior approval is not required for elective services received outside Alberta, with the exception of treatment of alcohol and substance abuse, eating disorders and similar addictive or behavioural disorders. To be eligible for coverage, these services, whether received out-of-province or out-of-country, must be approved by the Minister prior to being received.

Requests for prior approval for hospitalization and medical treatment outside Alberta but within Canada must be submitted to the Department by the physician responsible for the ongoing care of the patient in Alberta, or by the physician of the applicable provincial or territorial jurisdiction.

5.0 Accessibility

5.1 Access to Insured Health Services

Access to insured health services in Alberta is available to all residents on uniform terms and conditions, without barriers.

Those who are unable to pay premiums are not prevented from receiving insured health services. Registrations are not cancelled because of non-payment of accounts. Also, Alberta has two programs in place to assist lower-income persons with payment of premiums.

These programs are:

- ☐ the Premium Subsidy Program; and
- ☐ the Waiver of Premiums Program.

Extra-billing by physicians and user charges to hospital patients for insured services have been prohibited since 1986.

Alberta's Good Faith policy allows practitioners to submit claims for services provided to patients who are unable to provide an Alberta health care number at the time of service. This can be done one time only per patient and the practitioner must first be satisfied that the patient is an Alberta resident.

5.2 Access to Insured Hospital Services

The delivery of hospital services in Alberta has been the responsibility of the health authorities since 1994.

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[8] NOTE: This program also applies to treatment costs received outside of the Province, within Canada.

In 2001-2002, the following staffed beds in facilities providing insured hospital services were available in Alberta:

Acute care facilities (see definition in section 2.1)	6,533[9]
Chronic care facilities (see definition in section 2.1)	6,701[9]
Rehabilitative facilities	240[9]
TOTAL	13,474[9]

Measures taken in 2001-2002 to improve access to insured hospital services include:

- ☐ In April, 2001, the Government of Alberta announced its 2001-2002 to 2003-2004 business plan outlining increases to the provincial health system.
- ☐ Under this business plan the base budget for 2001-2002 was increased by 13.5 percent or $737 million, with total Alberta Health and Wellness spending in 2001-2002 of $6.325 billion.
- ☐ The regional health authorities and provincial boards received an increase of $338 million or 10.8 percent in 2001-2002. This included $264 million to improve compensation for nurses and other health care providers. The increase also included $17.8 million to enable Alberta to achieve a target of twenty-four MRI scans per thousand population.
- ☐ Regional health authorities also received an increase of $34 million or 10.8 percent for province-wide services for key life-saving procedures primarily done in Edmonton and Calgary.
- ☐ A further $48.9 million was provided to the health authorities for the purchase of medical equipment. This represents the second year of a $97.7 million funding commitment from the federal government for the purchase of high-tech equipment for diagnostic and treatment purposes.
- ☐ In November, 2001, an additional $200 million in funding was provided to health authorities. These funds were provided to help serve a growing population, meet a higher demand for services, offset the higher cost of supplies and help address staffing issues such as recruitment.
- ☐ $200,000 in one-time government funding was provided to fully cover the increase in the cost of malpractice insurance for registered midwives in Alberta.
- ☐ In the regional health authorities' quarterly reporting to Alberta Health and Wellness, volumes and wait times are reported on services such as: hip and knee replacement surgery; wait times in emergency for inpatient beds; Magnetic Resonance Imaging; Long Term Care Services; and Adult Open Heart Surgery. Provincial expectations and reporting requirements are detailed in *Health Authority Accountability for Targeted Funding 2001-2002* Appendix 3. These quarterly reports are published on Alberta Health and Wellness' web site at

  www.health.gov.ab.ca
- ☐ Wait times for cancer treatment are reported to Alberta Health and Wellness by the Alberta Cancer Board on a quarterly basis. Currently wait times are reported for breast and prostate cancer only, however plans are underway to expand reporting to the top five tumour groups which represent 70 percent of their case load.

5.3 Access to Insured Physician and Dental-Surgical Services

In 2001-2002, there were 5,079[9] physicians and 1,524[9] Oral Surgeons/Dentists who were registered with and submitted claims to the Alberta Health Care Insurance Plan.

Measures taken in 2001-2002 to increase access to insured physician and dental-surgical services include:

- ☐ significant increases in Alberta's medical school and medical residency seat numbers. These included the addition of 54 new medical school entry positions in Alberta's two facilities of medicine, and creation of the Alberta International Medical Graduate (AIMG) Program and the Alberta Rural Family

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[9] NOTE: These figures will be considered preliminary until the release of the Alberta Ministry of Health and Wellness' *Alberta Health Care Insurance Plan, Statistical Supplement 2001-2002.*

Medicine Network (ARFMN). There are currently 19 residents training in the AIMG Program. The ARFMN Program has a total of 40 family medicine residents. As well, the two medical facilities were provided increased funding to allow training of 32 additional residents.

- in response to the Premier's Advisory Council on Health report, the Alberta government has committed to the following:
    - work with physicians and regional health authorities to identify services that will have 90-day access guarantee. The guarantees will start to take effect in 2003;
    - launch a web site posting information on wait times for selected procedures in 2003;
    - have available a centralized booking system for selected procedures to allow patients to find a surgeon and facility that matches their needs in 2006; and
    - increase the use of care groups, which involve a range of health professionals and new approaches to care for people with chronic diseases, over the next three years.

5.4 Physician Compensation

On April 20, 1998, Alberta Health and Wellness and the Alberta Medical Association signed a five-year master agreement governing the provision of physician services to Albertans for the period 1998 to 2004. All prior agreements were terminated and superseded by this new agreement. The Agreement covers three years of financial arrangements, 1998-1999 to 2001-2002, under which Alberta Health and Wellness provides an adjustable hard cap to pay for the fee-for-service billings by physicians and a number of physician benefit programs. The agreement was ratified by a majority of the Alberta Medical Association membership.

In January, 2001, Alberta Health and Wellness and the Alberta Medical Association entered into an "amending agreement" to the April 20, 1998, Master Agreement. The terms of this amending agreement are in effect from April 1, 2001 to March 31, 2003, unless another effective date is expressed in any term of the Amending Agreement. Among other things, the Amending Agreement sets the Medical Service Budget for the 2001-2002 and 2002-2003 fiscal years, as well as the percentage to be used for estimating increases in population, when making adjustments to the adjustable hard-cap portion of the Medical Service Budget.

A Medical Services Delivery Innovation Fund to support the development of Alternate Payment Plans was also established by the Amending Agreement, as well as a Specialist On-Call Program to compensate specialist physicians for being on call and to enable them to meet their responsibility of ensuring patients have the required access to specialists. Under the terms of the Amending Agreement, Alberta Health and Wellness also committed to establishing an "On-Call Contingency Fund" to become effective April 1, 2002, for the purposes of funding changes that may arise from the review and evaluation of the effectiveness of Alberta physician on-call programs.

Section 4(1) of the *Alberta Health Care Insurance Act* provides the authority for the Minister to pay benefits in respect of health services provided to residents of Alberta. The Medical Benefits Regulation (AR173/93 effective April 1, 1993) defines the services for which benefits are payable, identifies the schedule under which the rates are identified and sets out the requirements for submission of claims to the Alberta Health Care Insurance Plan.

There were no changes made to this legislation in 2001-2002.

Fee Structures

Most physicians in Alberta are paid on a fee-for-service basis for providing insured services. Some physicians find the fee-for-service funding and payment model to be restrictive. The Department and the Alberta Medical Association are working with health authorities, facilities and physicians to develop a number of Alternate Payment Plan (APP) projects as alternatives to fee-for-service. To date, the joint AMA/Alberta Health and Wellness APP Subcommittee has developed four funding models. As with fee-for-service, APPs are funded from the Department's Medical Services Budget and **are not reflected in Annex A of this report** (see *Provincial and Territorial Health Care Insurance Plan Statistics*). In some circumstances, APP funding and fee-for-service may be blended in order to compensate physicians for services that are not part of the arrangement. APP projects may also be eligible for grant funding to help offset certain project-related expenses.

The APP Subcommittee has developed four funding models:

- **Capitation** funding is generally associated with the delivery of primary medical care. Per capita funding is provided for the comprehensive care of each patient over a set period of time. The capitation rate is calculated by taking a number of factors into account, including patient age and gender and the pre-determined range of services to be offered by the practice.
- **Sessional** funding is based on units of time (e.g. hourly or daily) spent in the provision of defined insured medical services within an organized structure or program. Sessional funding arrangements must be part of a regional health authority program, and must adhere to a set service delivery model.
- **Contractual** funding is provided as a lump sum for the provision of a pre-determined volume of insured medical services over a specified period, such as a year (e.g. X dollars paid for 100 patient encounters or for performing 500 procedures of a certain type).
- **Block Funding** is a negotiated amount paid to a group of physicians to provide all insured services in a specific area of medical practice over a significant period of time (e.g. X dollars for the provision of all neurosurgical services in Northern Alberta over a three-year period).

Alternate Payment Plan (APP) and Alternate Funding Plan (AFP) programs were expanded in 2001-2002. Two new projects were implemented bringing the total number of physicians involved in APPs to approximately 80 in seven projects. Eleven other APPs, involving approximately 250 physicians and four AFPs involving more than 200 academic physicians, are in varying stages of development. Thirty-eight applications from physicians for funding from the Medical Services Delivery Innovation Fund for APP development received preliminary approval.

5.5 Payments to Hospitals

The *Regional Health Authorities Act* sets out the requirements for the establishment and governance of Alberta regional health authorities. In Alberta, hospital services are provided by the regional health authorities.

In accordance with section 8 of the *Regional Health Authorities Act*, the authority must submit a proposal for a health plan for the region to the Minister. This proposal must contain a statement as to how the authority proposes to carry out its responsibilities and measure its performance in the carrying out of those responsibilities, as well as information respecting health services to be provided and the anticipated cost of providing those services.

Regional health authorities are funded by the provincial government using a population-based funding formula. Additional funding is provided to Edmonton and Calgary health authorities for the provision of specialized tertiary services (Province Wide Services) to all Albertans. In 2001-2002, $3.8 billion in population-based block funding, including Province Wide Services, was provided to the regional health authorities.

Regional health authorities are accountable and report to the Minister of Health and Wellness. The Minister has the authority to request records, reports and returns from the regions, as well as annual reports on their activities. The annual reports are subsequently presented to the Legislative Assembly by the Minister and are included in the *Alberta Ministry of Health and Wellness Annual Report*.

In 2001-2002, amendments respecting the election and appointment of board members were made to the *Regional Health Authorities Act*. Amendments were also made to the Regional Health Authorities Regulation to exempt regional health authorities from paying land titles fees when the Minister orders a transfer of property. Additional amendments were made respecting the accrual of deficits and the election and appointment of board members.

In 2001-2002, the Election and Appointment of Regional Health Authority Members Regulation came into force. This Regulation governs the election and appointment of regional health authority members.

In 2001-2002, the Election Forms Regulation came into force. This Regulation sets out forms to be used for the nomination and acceptance of the electoral candidates.

Amendments were also made to the Regional Health Authorities (Ministerial) Regulation. These amendments require hospitals to retain statements given to patients regarding the costs of enhanced medical goods or services and requiring financial performance and forecasted revenue and expenditure information to be provided to the Minister.

Amendments respecting the application of Regulations when boundaries change were also made to the Property and Assets (Transitional) Regulation in 2001-2002.

6.0 Recognition given to Federal Transfers

The Alberta government publicly acknowledged the federal contributions provided through the Canada Health and Social Transfer in its 2001-2002 Income Statement, in its three-year business plan and on a schedule of revenues in the Department's financial statements. These transfers are also listed in the Ministry's Annual Report. All documents are available to the public, through the Queen's Printers, on our web site at

www.health.gov.ab.ca,

or at public libraries throughout the Province.

7.0 Extended Health Care Services

Alberta's Long Term Care Centres provide room and board and a range of care services, from personal care with nursing supervision to skilled medical and therapeutic services. In most instances, these auxiliary hospitals and nursing homes are referred to as Continuing Care Centres and meet the needs of residents with similar care requirements. Funding for Continuing Care Centres has been transferred to the 17 regional health authorities. Regional health authorities either operate the Continuing Care Centres or sign contracts with voluntary or private operators to deliver these services.

The Home Care Program is also delivered through the regional health authorities and provides a variety of professional health support services to assist individuals of all ages to return or remain at home. All Home Care Programs provide assessment, case coordination and nursing and support services such as personal care and home support. Other services may include occupational, physical and respiratory therapy, speech-language pathology, social work and nutrition services.

Admission to the continuing care system, which includes Home Care, Continuing Care and Community Care Centres and Adult Day Programs, is based on a functional assessment of the individual's needs, using the Alberta Assessment and Placement Instrument. The Single Point of Entry process was developed to provide a single point of access to individuals seeking facility or community-based long-term care. Its purpose is to ensure that all possible community options are explored before facility-based care is considered. Home Care staff conduct assessments, identify needs with clients and their families, and recommend health and support services that best suit these needs.

Alberta Aids to Daily Living

The Department also administers the Alberta Aids to Daily Living (AADL) Program. The purpose of AADL is to enhance the independence of clients living at home who have a chronic or terminal illness or disability, by assisting them with the provision of program-approved medical equipment and supplies. Clients are assessed for eligibility by authorizers working in community care, continuing care or acute care settings.

Alberta Mental Health Board, Mental Health Services

Mental health services delivered by the Alberta Mental Health Board (AMHB) include community clinics, two mental health hospitals, two care centres, 67 community mental health clinics and three satellite offices, as well as various non-profit community agencies. Services provided by the clinics include assessment and treatment of individuals and families and consultation to physicians, health facilities, health units, schools and community agencies. Two mental health hospitals provide assessment, treatment and rehabilitation for adults with mental illnesses, including mentally ill offenders, and for adults with brain injuries. Two residential care centres provide long-term rehabilitation programs for people with severe mental illness. The AMHB also provides the governance function for four mental health provincial programs: Forensic Psychiatry, Geriatric Psychiatry, Adult Tertiary Care and Brain Injury.

Other mental health services provided by regional health authorities include specialized psychiatric services located in 17 hospitals throughout the Province. Family physicians, Home Care Programs and Continuing Care Centres also provide services to people with mental illness.

Alberta Cancer Board

In 2001-2002, the Department provided $139.5 million to the Alberta Cancer Board to support its operations and various research programs.

8.0 Additional Materials Submitted to Health Canada

- ☐ *Schedule of Medical Benefits, April 1, 2002*;
- ☐ *Schedule of Oral and Maxillofacial Surgery Benefits, August 1, 2001*;
- ☐ Reports of the Auditor General of Alberta for 2001-2002.

Office consolidations of all health care insurance legislation, as identified under the public administration section of our narrative, together with all relevant regulations:

- ☐ *Alberta Health Care Insurance Act*;
- ☐ Alberta Health Care Insurance Regulation;
- ☐ *Government Accountability Act*;
- ☐ *Health Care Protection Act*;
- ☐ Health Care Protection Regulation;
- ☐ *Health Insurance Premiums Act*;
- ☐ Health Insurance Premiums Regulation;
- ☐ Hospitalization Benefits Regulation;
- ☐ *Hospitals Act*;
- ☐ Hospital Foundation Regulation;
- ☐ Medical Benefits Regulation;
- ☐ *Medical Profession Act*;
- ☐ *Nursing Homes Act*;
- ☐ Nursing Homes General Regulation;
- ☐ *Regional Health Authorities Act*;
- ☐ Regional Health Authorities Regulation.

Reports giving recognition to federal contributions provided under the Canada Health and Social Transfer (CHST):

- ☐ *Alberta Ministry of Health and Wellness Annual Report, 2001-2002*;
- ☐ *Ministry of Health and Wellness Three-Year Business Plan, 2002-2005*;
- ☐ Alberta Budget, 2001-2002.

British Columbia

Introduction

British Columbia has a progressive and integrated health care system. The British Columbia health system includes insured services under the *Canada Health Act* as well as services funded wholly or partially by the Government of British Columbia and services regulated by, not funded by, the government. It is based on regional delivery and self-regulating professional colleges providing quality, accessible and affordable health care. Health authorities are responsible for the delivery and management of health services in each community of British Columbia. As of March 31, 2002, there were five regional health authorities plus a Provincial Health Services Authority.

Health care is a top priority for the Government and people of British Columbia.

Activities for 2001-2002

Much of the focus during 2001-2002 was on changes required to renew the public health care system in British Columbia in order for it to be sustainable while meeting the health care needs of its residents. Over the past decade, health spending increased from about 33 percent to almost 39 percent of the provincial budget, and in 2001-2002, the Ministry of Health Services budget increased by $1.1 billion to $9.5 billion. Increases of this magnitude are not sustainable.

In June, 2001, the former Ministry of Health and Ministry Responsible for Seniors was restructured into two new ministries to meet health challenges and to enhance health care in British Columbia. The Ministry of Health Services provides funding, strategic direction and leadership to support the delivery of health care, preventive health and health promotion services in British Columbia. The Ministry of Health Planning supports the development of long-term planning necessary to sustain British Columbia's public health care system in the years ahead.

There was also a significant restructuring of health authorities in December 2001 to focus on patient care and minimize the duplication of administrative services under the previous structure which included 52 health authorities. There are now five regional health authorities responsible for managing and delivering a range of health services, including acute and hospital care, home and community care, mental health, addictions, and public health services. These five regional health authorities encompass 15 health services delivery areas, which were established to reflect natural patient referral patterns. A Provincial Health Services Authority has been established to coordinate and deliver highly specialized services that can't be offered in all regions, and to facilitate coordination of provincial initiatives. Health authorities now receive three-year budgets, which assists in planning, and have greater accountability through performance agreements that define expectations and performance deliverables for three fiscal years. The performance agreements also set out the major change requirements in areas of service such as emergency care, surgical services, home and community care, public and preventive health, and mental health. A new population-needs-based funding formula was developed in 2001-2002 for implementation in 2002-2003.

A number of measures were undertaken in 2001-2002 to improve access and to reduce waiting times for insured hospital services. Capital and operating funding of $63 million was approved for health authorities to buy diagnostic equipment such as CT scanners, modern clinical equipment for operating rooms and laboratories, and new beds and lifts to prevent injuries to health care workers.

A wide range of capital projects was funded to provide new and improved health care facilities.

In 2001, the Government allocated $21 million for a new Nursing Strategy and hired BC's first Chief Nurse Executive. The strategy addresses the Province's nursing shortage and improves working conditions for nurses.

The Ministry of Health Planning has prepared acute care access standards that are being used by health authorities in the redesign of hospital services. The standards specify the maximum travel time for accessing emergency services, in-patient services and core specialty services. They also ensure that the majority of British Columbians, in all regions, have reasonable access to these services.

Information on health and health care in British Columbia is available from the following website:

www.gov.bc.ca/healthservices
www.gov.bc.ca/healthplanning

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

On January 1, 1949, the British Columbia provincial government commenced making payments to hospitals for treatment provided to qualified residents under the authority of the *Hospital Insurance Act*. Hospital services are funded, on a non-profit basis, through the Performance Management and Improvement Division of the Ministry of Health Services. This program is responsible to the provincial government for the ongoing funding of the Province's public hospitals, delivered via funding and transfer agreements with the six health authorities, under the terms of the *Hospital Act*, the *Hospital Insurance Act* (section 9), and the *Hospital District Act* (section 20). This entails expenditures and commitment controls for the operation of hospitals, provision of funds for hospital construction and equipment, and payment of out-of-province hospital costs for qualified British Columbia residents.

Section 9 of the *Hospital Insurance Act* requires that the Minister annually pay an amount to all hospitals to cover the costs of publicly insured hospital services. Proposed housekeeping amendments to the Act, which are expected to proceed in spring of 2003, will reflect the fact that government funding of insured hospital services is now provided to hospitals through the funding of health authorities.

The Medical Services Plan of British Columbia is administered and operated on a non-profit basis by the Medical Services Commission. The Medical Services Commission is responsible to the Minister of Health Services and facilitates, in the manner provided for under the *Medicare Protection Act* (1996), reasonable access to insured benefits under British Columbia's Medical Services Plan by beneficiaries (residents). The day-to-day administration is carried out by the employees of the Medical Services Plan of the Ministry of Health Services. Section 3 of the *Medicare Protection Act* establishes both the Medical Services Plan and the Medical Services Commission.

The Commission's powers (set out under section 5 of the *Medicare Protection Act)* include determining benefits, registering beneficiaries, enrolling practitioners, processing and paying practitioners' bills for benefits rendered, registering diagnostic facilities, establishing advisory committees, authorizing research and surveys related to the provision of benefits, auditing claims for payment and patterns of practice or billings submitted, and hearing appeals from practitioners and beneficiaries.

There were no amendments to the *Medicare Protection Act* or the Medical and Health Care Services Regulation made under the *Medicare Protection Act* in 2001-2002, that changed the name of the plan or its public authority.

1.2 Reporting Relationship

Health authorities are required to report health information data respecting hospitals in their jurisdictions to the Ministry of Health Services in accordance with provincial policy. The Performance Management and Improvement Division reports to government through the *Ministry of Health Services Annual Report*.

The Medical Services Commission reports annually to the Minister of Health Services in a separate Financial Statement. The 2001-2002 Financial Statement was tabled in October, 2002.

In their annual performance reports, the Ministries of Health Planning and of Health Services provide extensive information on the performance of BC's publicly-funded health care system. Tracking and reporting this information is consistent with the Ministries' increasingly strategic approach and responsibilities for performance planning and reporting, under the *Budget Transparency and Accountability Act*, which was passed in 2000.

1.3 Audit of Accounts

The Performance Management and Improvement Division and the Medical Services Commission are subject to audit of their accounts and financial transactions through three types of auditor. Internally, the Ministry of Health Services Finance and Decision Support Unit reviews Ministry operations.

The Office of the Comptroller General's Internal Audit and Advisory Services is the provincial government's internal auditor and the Office of the Auditor General (OAG) of British Columbia is responsible for conducting audits and reporting its findings to the Legislative Assembly. The OAG initiates its own audits and the scope of its audits. The Public Accounts Committee of the Legislative Assembly reviews the recommendations of the OAG and determines when the Ministry has complied with the findings. The Comptroller General determines the scope of the internal audits and timing of the audits in consultation with the audit committee of the Ministry of Health. The Ministry's Senior Financial Officer determines the scope and timing of reviews conducted by the Finance and Decision Support Unit.

2.0 Comprehensiveness

2.1 Insured Hospital Services

The *Hospital Insurance Act* establishes public insurance coverage for general hospital services. Eligibility is defined by the Regulations, which include both a residency requirement and a waiting period. Insured hospital services are provided in facilities specified in section 1 of the *Hospital Insurance Act*. In 2001-2002 there were 94 acute care hospitals, 3 rehabilitation hospitals, 18 free-standing extended care hospitals and 25 diagnostic and treatment and other health centres.

Insured hospital services are provided as recommended by the attending physician or midwife. These services, and the conditions under which they are provided, are listed in the *Hospital Insurance Act Regulations*, Division 5. Insured in-patient services provided by hospitals are:

- ☐ accommodation and meals at the standard or public ward level;
- ☐ necessary nursing services;
- ☐ laboratory and radiological procedures and necessary interpretations together with such other diagnostic procedures as approved by the Minister;
- ☐ clinically approved drugs, biologicals and medical supplies, when administered in a general hospital specified in the *Hospital Insurance Act*;
- ☐ routine surgical supplies;
- ☐ use of operating room and case room facilities;
- ☐ anaesthetic equipment and supplies;
- ☐ use of radiotherapy, physiotherapy and occupational therapy facilities, where available; and
- ☐ other services approved by the Minister that are rendered by persons who receive remuneration from the hospital.

Qualified persons not requiring in-patient hospital care may receive emergency treatment for injuries or illness and operating room or emergency room services for surgical day care and minor surgery, including the application and removal of casts.

Listed hospital out-patient benefits include:

- ☐ out-patient renal dialysis treatments in designated hospitals or other approved facilities;
- ☐ diabetic day-care services in designated hospitals;
- ☐ out-patient dietetic counselling services at hospitals with qualified staff dieticians;
- ☐ psychiatric out-patient and day-care services; physiotherapy and rehabilitation out-patient day care, and services;
- ☐ cancer therapy and cytology services;
- ☐ out-patient psoriasis treatment;
- ☐ abortion services; and
- ☐ MRI services.

Insured hospital services are provided at no charge to beneficiaries. Incremental charges for preferred medical/surgical supplies are made on the basis of a patient's request. The patient is not required to pay the incremental charge if the preferred service is deemed medically necessary by the attending physician.

Ambulance services are provided within the Province by the British Columbia Ministry of Health Services through the Emergency Health Services Commission, with a partial charge to the patient.

In 2001-2002, no new services were added to the list of insured hospital services covered by the *Hospital Insurance Act*. General hospital services are set out in sections 5 and 8 of the *Hospital Insurance Act*. The hospital services listed in the Regulations are both comprehensive and generic, and the last change to the list, which was only an update to an existing item, was in 1996. The process for changing the listed items is the same as for in any change to the Regulations.

2.2 Insured Physician Services

Insured physician services are provided under the authority of the *Medicare Protection Act* (1996). Section 13 of the *Medicare Protection Act* (MPA) provides that practitioners (including medical practitioners and health carepractitioners, such as dentists) who are enrolled and who render benefits to a beneficiary are eligible to be paid for services rendered in accordance with the appropriate payment schedule.

The Medical Services Plan (MSP) provides for medically required services of medical practitioners. Unless specifically excluded, the following medical services are insured as MSP benefits under the MPA and in accordance with the *Canada Health Act*:

- ☐ medically required services provided to "beneficiaries" (residents of British Columbia) by a medical practitioner enrolled with MSP; and
- ☐ medically required services performed in an approved diagnostic facility under the supervision of an enrolled medical practitioner.

To practise in British Columbia, physicians must be registered and in good standing with the College of Physicians and Surgeons of British Columbia. To receive payment for insured services, they must be enrolled with the MSP. There were 7,810 physicians enrolled and billing fee-for-service in fiscal year 2001-2002. In addition, some physicians practice solely on salary, receive sessional payments, or are on contract (service agreements) arrangements under alternative payments. Most physicians paid by alternative mechanisms also practise on a fee-for-service basis.

A physician may choose not to enrol or to de-enrol with the Medical Services Commission. Enrolled physicians may cancel their enrolment by giving 30 days' written notice to the Commission. Services provided by un-enrolled physicians are not benefits and patients are responsible for the full cost of the service. There was one previously enrolled physician who had de-enrolled as of March 31, 2002.

Enrolled physicians can elect to be paid directly by beneficiaries by giving written notice to Commission. The Commission will specify the effective date between 30 and 45 days following receipt of the notice. In this case, beneficiaries may apply to the MSP for reimbursement of the fee for insured services rendered. Only six physicians had opted out as of March, 2002.

In April, 2002, under the *Health Services Statutes Amendment Act* (2002), several amendments were made to the *Medicare Protection Act* with respect to insured physician services. The amendments: repeal section 13.1 to eliminate mandatory de-enrollment of physicians from billing the MSP at age 75; amend section 37 to provide for surcharge and interest charges against physicians who receive money from the Commission for services they did not provide; and amend section 37 to allow the Commission to order interest on inappropriate billings retroactive to the billing period. The amendments were brought into force under Orders in Council 557/02 and 558/02 on July 4, 2002.

Under the Master Agreement between the Commission and the British Columbia Medical Association (BCMA), additions, deletions, fee changes or other modifications to the Commission Payment Schedule are made by the Commission, upon advice from the BCMA. Physicians who wish to have modifications to the Schedule considered submit their proposals to the BCMA Tariff Committee through the appropriate section. On recommendation of the BCMA Tariff Committee, interim listings may be designated by the Commission for new procedures or other services for a limited period of time to allow definitive listings to be established, if appropriate.

Several new fee items were added in 2001-2002, as follows:

- patient activated cardiac event recorders;
- photo epilation of facial hair;
- drugs of abuse testing;
- flexible oesophagoscopy for removal of foreign material causing obstruction;
- helicobacter pylori Carbon 13 urea breath test;
- helicobacter pylori Carbon 14 urea breath test;
- chlamydia trachomatis using NAT; and
- sirolimus.

A number of new clinical practice guidelines were also approved by the Commission:

- antiepileptic drug concentration measurement in adults;
- detection of drugs of abuse in urine: methadone maintenance program;
- investigation and management of iron overload;
- antinuclear antibody (ANA) testing for connective tissue disease; and
- use of haematology profile in adults.

2.3 Insured Surgical-Dental Services

The Medical Services Plan provides for specified dental or oral surgery when it is medically or dentally necessary for it to be performed in hospital by a dental or oral surgeon. Any dental or oral surgeon in good standing with the College of Dental Surgeons and enrolled in the Medical Services Plan may provide insured surgical-dental services in hospital. There were 275 dentists enrolled and billing fee-for-service in 2001-2002. None have de-enrolled and none have opted out of the Medical Services Plan.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

For out-patients, take-home drugs and certain hospital drugs are not insured, except those provided under the provincial Pharmacare program. Other procedures not insured under the *Hospital Insurance Act* are:

- diagnostic out-patient services not associated with emergency services;
- the services of medical personnel not employed by the hospital;
- treatment for which the Workers' Compensation Board, the Department of Veterans Affairs or any other agency is responsible;
- services solely for the alteration of appearance; and
- reversal of sterilization procedures.

Uninsured hospital services also include:

- preferred accommodation at the patient's request;
- televisions, telephones and private nursing services;
- preferred medical/surgical supplies;
- dental care that could be provided in a dental office including prosthetic and orthodontic services; and
- preferred services provided to patients of extended care units or hospitals.

Services not insured under the Medical Services Plan are:

- those covered by the *Workers' Compensation Act* or by other federal or provincial legislation;
- provision of non-implanted prostheses;
- orthotic devices;
- proprietary or patent medicines;
- any medical examinations that are not medically required;
- oral surgery rendered in a dentist's office;
- acupuncture;
- group immunizations;
- telephone advice unrelated to insured visits;

☐ reversal of sterilization procedures;

☐ *in-vitro* fertilization;

☐ medico-legal services;

☐ cosmetic services; and

☐ preventive medical counselling, for example, smoking withdrawal programs.

Medical necessity, as determined by the attending physician and hospital, is the basis for access to hospital and medical services.

The *Medicare Protection Act*, section 45 prohibits the sale or issuance of health insurance by private insurers to beneficiaries for services that would be benefits if performed by a practitioner. Section 17 of the Act prohibits persons from charging a beneficiary for a benefit or for "materials, consultations, procedures, use of an office, clinic or other place or for any other matters that relate to the rendering of a benefit." The Ministry of Health Services responds to complaints made by patients and is prepared to take appropriate actions to correct situations identified to the Ministry.

The Medical Services Commission determines which services are benefits and has the authority to de-list insured services. Proposals to de-insure services must be made to the Commission. Consultation may take place through a sub-committee of the Commission and usually includes a review by the British Columbia Medical Association's Tariff Committee.

3.0 Universality

3.1 Eligibility

Provincial policy on eligibility for hospital services is set out in Chapter 2 of the Ministry of Health Service's Acute Care Policy Manual.

Section 7 of the *Medicare Protection Act* defines the eligibility and enrolment of beneficiaries for insured services. Part 2 of the Medical and Health Care Services Regulations made under the *Medicare Protection Act* details residency requirements. A person must be a resident of British Columbia in order to qualify for provincial health care benefits. The *Medicare Protection Act*, in section 1, defines a resident as a person who is a citizen of Canada or is lawfully admitted to Canada for permanent residence, makes his or her home in British Columbia, and is physically present in British Columbia at least six months in a calendar year. The definition of resident includes a person who is deemed under section 2 of the Medical and Health Care Services Regulations to be a resident but does not include a tourist or visitor to British Columbia.

All residents, excluding those eligible for compensation from another source, are entitled to hospital and medical care insurance coverage. The Medical Services Plan provides first-day coverage to discharged members of the Royal Canadian Mounted Police and the Canadian Forces, and to released inmates of federal penitentiaries. However, if discharged outside British Columbia, they must wait the prescribed period.

3.2 Registration Requirements

As of April 1, 1998, residents must be enrolled in the Medical Services Plan to receive insured hospital and physician services. Those who are eligible for coverage are required to enrol. Once enrolled, there is no expiration date for coverage. New residents are advised to make application immediately upon arrival in the Province. Each person who enrols with the Medical Services Plan is issued a CareCard. Renewal of cancelled enrolment can usually take place over the telephone, by calling the Medical Services Plan.

Beneficiaries may cover their dependants, provided the dependants are residents of the Province. Dependants include the account holder's spouse (either married to or living and cohabiting in a marriage-like relationship), any unmarried child or legal ward under the age of 19 supported by the beneficiary, or a child under the age of 25 and in full-time attendance at a school or university.

The number of residents registered with the Medical Services Plan as of March 31, 2002, was 4.08 million. Enrolment in the Medical Services Plan is mandatory. Only those adults who formally opt out of all provincial health care programs are exempt. As of March 31, 2002, 218 people had opted out.

3.3 Other Categories of Individual

Refugee claimants are not generally eligible. Individuals who are approved for refugee status and who are, therefore entitled to reside in Canada on a permanent basis, are eligible. Under specific circumstances, special consideration is given to these individuals regarding the effective date of benefits. Holders of Minister's Permits are eligible for benefits where deemed to be residents under the Medical and Health Care Services Regulation. A waiting period applies.

3.4 Premiums

Enrolment in the Medical Services Plan is mandatory, and payment of premiums is ordinarily a requirement for coverage. However, failure to pay premiums is not a barrier to coverage for those who meet the basic enrolment eligibility criteria. During 2001-2002, monthly premiums for the Medical Services Plan were $36 for one person, $64 for a family of two, and $72 for a family of three or more. Residents with limited means may be eligible for premium assistance. There are five levels of assistance, ranging from 20 percent to 100 percent of the full premium. Premium assistance is available only to beneficiaries who, for the last 12 consecutive months, have been resident in Canada and a Canadian citizen or holder of permanent resident (landed immigrant) status.

There are no additional premiums for insured hospital services. However, there is a daily charge for extended-care hospital services for patients over the age of 19. The client rate, representing the cost of accommodation and meals, is established once a year. As of March 31, 2001, the maximum non-subsidized rate was $50 a day. Residents with limited means are eligible for assistance, on a sliding scale, being 85 percent of the Old Age Security and Guaranteed Income Supplement. In certain circumstances there is a provision to waive a portion of the $27.00 (as of March 31, 2002) fee. Client rates of less than $50 per day are reviewed quarterly and patients are advised one month before any changes are made.

4.0 Portability

Persons moving permanently to another part of Canada are entitled to coverage to the end of the second month following the month of departure. Such persons may be extended coverage, not to exceed three months, for a reasonable period of travel.

Persons moving permanently outside Canada are entitled to coverage to the end of the month of departure.

4.1 Minimum Waiting Period

The minimum residence requirement for hospital insurance and medical care coverage is a waiting period ending at midnight on the last day of the second month following the month in which the individual becomes a resident.

Coverage is available to landed immigrants who have completed the waiting period. Also after the waiting period, coverage is available to persons from outside Canada who are in the Province on work permits or student visas, provided the permits or visas are valid for at least six months, and have been issued at the time of admission to Canada.

4.2 Coverage During Temporary Absences In Canada

Sections 3, 4 and 5 of the Medical and Health Care Services Regulations define portability provisions for persons temporarily absent from British Columbia in Canada with regard to insured services. In 2001-2002, there were no amendments to the Medical and Health Care Services Regulation, made under the *Medicare Protection Act*, with respect to the portability provisions.

Section 17 of the *Hospital Insurance Act* empowers the Minister of Health to enter into an agreement with any other province or territory to bring about a high degree of liaison and cooperation among the Provinces concerning hospital insurance matters, and to make arrangements under which a qualified person may move his or her home from one province or territory to the other without ceasing to be entitled to benefits.

Individuals who leave the Province temporarily on extended vacations or for temporary employment may be covered for up to 12 months. Approval is limited to once in five years for such absences exceeding six months in a calendar year. Residents who spend part of every year outside British Columbia must be physically present in Canada for at least six months in a calendar year and continue to maintain their homes in British Columbia. Students attending a recognized school in another province or territory on a full-time basis are entitled to coverage for the duration of their studies.

According to inter-provincial and inter-territorial reciprocal billing arrangements, physicians, except in Quebec, bill their own medical plans directly for services rendered to eligible British Columbia residents, on presentation of a valid Medical Services Plan Card (CareCard). British Columbia then reimburses the Province or territory at the rate of the fee schedule in the Province or territory in which services were rendered. For in-patient hospital care, charges are paid at the standard ward rate actually charged by the hospital. For out-patient services, the payment is at the interprovincial and interterritorial reciprocal billing rate. Payment for these services, except for excluded services that are billed to the patient, is handled though interprovincial and interterritorial reciprocal billing procedures.

The Financial Administration section of the Acute Care Policy Manual sets out the specific details of the current interprovincial or territorial reciprocal billing agreement for insured hospital services. Each provincial hospital insurance plan will process hospital in- and out-patient accounts on behalf of the residents of the other provinces and territories, with the exception of Quebec, which is not a signatory to the Agreement. The Agreement covers benefits rendered within provincial or territorial boundaries and makes provision for the periodic settling of accounts between provinces and territories.

4.3 Coverage During Temporary Absences Outside Canada

The *Hospital Insurance Act* Regulations, division 4 and sections 3, 4, and 5 of the Medical and Health Care Services Regulations define portability of insured hospital and physician services during temporary absences outside Canada. In 200-2002, there were no amendments to the Medical and Health Care Services Regulation with respect to portability provisions.

A qualified person leaving British Columbia to attend university, college or other educational institutions recognized by the Medical Services Commission, on a full-time basis, retains eligibility during the absence for study until the last day of the month in which the person ceased full-time attendance at that educational institution, or if studying outside Canada, the last day of the sixtieth month since the date of departure from British Columbia.

A qualified person who is absent from British Columbia for vacation or work for more than six months is deemed a resident for the purpose of determining beneficiary status for up to the initial 12 consecutive months of absence, if this person obtains prior approval from the Medical Services Commission, does not establish residency outside BC and has not been granted approval for a similar absence during the preceding 60 months.

With prior authorization, coverage is provided for hospital services not available in Canada at the hospital's usual and customary rate. In other circumstances, with prior authorization, in-patient coverage is at the established standard ward rate. Renal dialysis day care is available at the interprovincial and interterritorial Canadian rate. In all other cases, including emergency or sudden illness during temporary absences from the Province, in-patient hospital care is paid up to $75 Canadian per day for adults and children, and $41 Canadian per day for newborns.

Out-of-country medical services are covered for emergency or sudden illness during temporary absences from the Province. These are paid up to the same fee payable for that service, had it been performed in British Columbia. Cases pre-authorized because of extenuating circumstances, however, are paid at the rate applicable where the service is rendered. With prior authorization, payment for non-emergency medical services outside the country may be made at usual and customary rates, when the appropriate treatment is not available in the Province or elsewhere in Canada.

4.4 Prior Approval Requirement

No prior approval is required for elective procedures that are covered under the interprovincial reciprocal agreements with other provinces. Prior approval from the Medical Services Commission is required for procedures that are not covered under the reciprocal agreements. Some treatments may require the approval of Performance Management and Improvement Division (e.g., treatment for anorexia). All non-emergency procedures performed outside of Canada require approval from the Commission prior to the procedure.

5.0 Accessibility

5.1 Access to Insured Health Services

British Columbia believes that all residents have reasonable access to hospital and medical care services. Beneficiaries, as defined in section 1 of the *Medicare Protection Act* and the Ministry of Health Services' Acute Care Policy Manual, are eligible for all insured hospital and medical care services as required. To ensure equal access to all, regardless of income, the *Medicare Protection Act*, Part 4, prohibits extra-billing by enrolled practitioners.

5.2 Access to Insured Hospital Services

In 2001-2002, there were 9,318 approved acute care beds in 94 acute care facilities, and 475 rehabilitation beds in acute care or rehabilitation hospitals. In addition, there were 25 diagnostic and treatment centres and six Red Cross Outpost hospitals.

The Province also provides access to care services for extended care patients. In 2001-2002, there were 18 free-standing extended care facilities, and a total of 7,334 extended care beds.

The number of practising Registered Nurses as of December, 2001 was 29,539. British Columbia hospitals also employ Registered Psychiatric Nurses (RPNs) and Licensed Practical Nurses (LPNs). In 2001 there were 2,181 RPNs and 4,469 LPNs. In 2001, the Government allocated $21 million for a new Nursing Strategy and hired BC's first Chief Nurse Executive. The strategy addresses the Province's nursing shortage and improves working conditions for nurses. The strategy includes more education seats; initiatives to encourage BC nurses who are not working in their profession to return to the health system; recruitment of more foreign-educated nurses; new opportunities for nurses to upgrade their skills; and funding for new equipment that will help nurses avoid workplace injuries.

The Government has been working with the federal government through the Canada Health Infostructure Partnership Program to facilitate telehealth options in the Province. The largest of the four projects currently underway, the BC telehealth program, offers videoconferencing services in the areas of emergency/trauma, continuing medical education, maternal and child, and paediatric palliative care. The emergency/trauma component of this program began in February, 2002, in two communities. In its first month of operation, 17 seriously ill or injured patients were able to be treated in their own communities through telehealth.

The Ministry of Health Planning has prepared acute care access standards that are being used by health authorities in the redesign of hospital services. The standards specify the maximum travel time for accessing emergency services, in-patient services and core specialty services. They also ensure that the majority of British Columbians, in all regions, have reasonable access to these services.

In 2001-2002, the Ministry of Health Services undertook a review of the capital budget process and a review of all ongoing capital projects for affordability. The result of this review was a new capital budget process where the Ministry would provide funding for:

- ☐ legally committed projects;
- ☐ priority projects such as:
  - mental health plan implementation,
  - academic space,

  - capital equipment including $63 million for diagnostic equipment, clinical equipment for operating rooms and labs, and new beds and lifts to prevent injuries to health care workers,
  - Fraser Valley Health Centre and Eastern Fraser Valley Cancer Centre and
  - Omenica Lodge; and
- service rationalization projects resulting from health authority restructuring.

For all other capital projects, health authorities will be required to fund all financing and operating costs from their existing operating budgets.

The new capital budget process sets the framework for 2002-2003 and beyond. With the restructuring of health authorities and the introduction of service plans and performance agreements, health authorities will have the ability and incentive to ensure appropriate utilization and maintenance of hospital facilities and equipment to meet the needs of patients and providers.

A number of capital construction projects completed in 2001-2002 provided new and improved health care facilities for British Columbians. The major projects completed included:

- Construction completed on the new $22.3 million Ambulatory Care Building and Emergency Expansion at BC Children's Hospital in March, 2002. The new unit is designed to meet the increasing demand for clinic and day surgery services. The five-story building will provide more patient and family amenities such as breastfeeding rooms, quiet rooms, change rooms and expanded waiting rooms with play areas.
- The $1.6 million, 10-bed multi-level care addition at the Royal Victoria Hospital in Kaslo was completed in July, 2001.
- The $14.7 million SUCCESS Care Home opened in October, 2001. The new facility has 103 multi-level care beds.
- The new $6.6 million South Similkameen Health Centre and 25-bed multi-level care facility opened in Keremeos in 2001.
- The $38.3 million Kitimat Hospital and Health Care Centre was completed in March, 2002.

  The new facility includes 22 acute care beds, maternity, day surgery, ambulatory care, diagnostic imaging, laboratory, pharmacy, rehabilitation, community health services, adult day centre and administrative support. The new multi-level care building and Adult Day Care component will include 36 beds, 9 of which will be special care, the Adult Day Care and enclosed link to the acute care building.
- The new $6.2 million Cormorant Island Health Centre in Alert Bay opened in March, 2002. The new hospital replaced St. George's Hospital and will provide acute care, multi-level care, diagnostic and treatment facilities, community health programs and support services.
- Yuculta Lodge in Campbell River opened in October, 2001. The $10.9 million multi-level care facility has 100 new beds.
- The $37.9 million West Coast General Hospital and the $4.3 million multi-level care facility were completed in August, 2001. The new acute care facility replaces the hospital built in the early 1950s. The multi-level care facility has 32 beds.
- The $1.5 million 16-bed hospice at St. Michael's Hospital in Burnaby was completed in March, 2002.
- The $6.3 million infrastructure upgrade at Fort St. John Hospital was completed in January, 2002.
- Construction of the Detox-Assessment and Treatment Centre for Women and Children in Prince George was completed in September, 2001. The new $4.5 million centre includes three separate areas for women, youth and women with children.
- Connolly Lodge, a 20-bed mental health residential care facility on the Riverview site opened in March 2002. The $1.6 million facility will provide 24 hour supervised care to clients who can benefit from greater independence and do not require hospitalization.
- Iris House, the new specialized mental health facility on the grounds of Prince George Regional Hospital, was completed in March, 2002. The $1.3 million 10-bed home-like facility will help house and care for people with serious or persistent mental

illness, providing assessment, treatment and rehabilitation.

- ☐ A new $1.5 million Canadian Red Cross Outpost Hospital in Bamfield was completed in November, 2001.
- ☐ The $116 million diagnostic and treatment redevelopment project at Royal Jubilee Hospital in Victoria was completed in March, 2002. The diagnostic and treatment centre includes diagnostic imaging, laboratory, pharmacy, cardiology, emergency, intensive care and coronary care units.

Additionally, the Province has introduced an integrated self-care program that includes telephone triage, health information and advice provided 24 hours per day, 365 days per year by specially trained registered nurses. Access to the BC NurseLine, implemented in April, 2001, includes local and provincial toll-free dialling and TTY services for deaf and hearing-impaired persons. In addition, simultaneous translation services are available in 130 languages. The NurseLine received approximately 103,000 calls in 2001-2002. The other two components of the program are the BC HealthGuide handbook, which was delivered to every BC household in March, 2001, and BC HealthGuide OnLine, which provides information on over 2,500 topics to all persons with a BC personal health number (www.bchealthguide.org).

5.3 Access to Insured Physician and Dental-Surgical Services

There were 4,430 general practitioners, 3,380 specialists and 275 Dentists who provided insured fee-for-service physician and dental-surgical services in 2001-2002.

The Ministry of Health Services initiated the Physician Recruitment and Retention Program to address workload and practice issues of doctors working in rural and remote areas of BC. Changes made to the Physician Recruitment and Retention Program included developing a new payment program for rural physicians. Through the Northern and Isolation Travel Assistance Outreach Program, funding was provided for an estimated 1,452 visits by family doctors and specialists to 55 rural communities. The Northern and Rural Locum Program was expanded, and assisted physicians practising in approximately 70 small communities to secure subsidized continuing medical education and vacation relief. The Rural Education Action Plan supported the training of physicians in rural practice through several components, including rural practice experience for medical students and enhanced skills for practising physicians.

5.4 Physician Compensation

The Province of British Columbia negotiates with the British Columbia Medial Association to establish the conditions, benefits and overall compensation for both fee-for-service physicians and physicians paid under alternative payment mechanisms, including salaried physicians.

The Government of British Columbia and the British Columbia Medical Association signed a Memorandum of Understanding on March 26, 2002, to provide for retroactive fee increases for 2001-2002, as well as a process for resolving outstanding issues. The resulting Working and Subsidiary Agreements signed in November of 2002 provided retroactive payments equivalent to 6.2 percent for the period April 1 to October 31, 2001 and 11.6 percent for the period November 1, 2001 to March 31, 2002. The Agreement also provided for retroactive payments totalling $80 million for on-call services provided during 2001-2002.

During 2001-2002, the Medical Services Plan's (MSP) payments to physicians in the Province totalled approximately $1.79 billion. For physician services provided out-of-province, including those within Canada and outside the country, the MSP paid approximately $19.3 million, of which approximately $14.9 million was for reciprocal payments to other provinces or territories.

Section 13 of the *Medicare Protection Act* provides that practitioners (including medical practitioners and health care practitioners, such as dentists) who are enrolled under the Act and who render benefits to a beneficiary are eligible to be paid for services rendered in accordance with the appropriate payment schedule. Section 13.1 of the Act which required mandatory de-enrolment of physicians from billing the Medical Services Plan at age 75, was repealed in 2002 under the *Health Services Statutes Amendment Act*, 2002. That amendment came into force on July 4, 2002.

Payment for medical services delivered in the Province is made through the MSP to individual physicians, based on billings submitted. The patient is not normally involved in the payment system. Ninety-eight percent of claims are submitted electronically through the Teleplan System, while the remaining two percent are submitted on claim cards by low-volume physicians and other health care practitioners.

The Medical Services Commission also funds comprehensive programs of health care services through contracted physician arrangements. The Ministry of Health Services' Clinical Services Contracts (CSC) Branch administers program-specific funding to British Columbia's six health authorities, which in turn, contract with physicians for their services or time through service contracts or sessional payments. Approximately 2,200 physicians are supported through the CSC's alternative funding arrangements.

5.5 Payments to Hospitals

Section 9 of the *Hospital Insurance Act* requires that the Minister annually pay an amount to all hospitals to reimburse them for the costs of providing publicly insured hospital services. Effective December 12, 2001, as part of its health care restructuring initiative to increase efficiencies and accountabilities for health authorities, Government restructured BC's regional health authorities by amalgamating 52 health authorities into five regional health authorities. Proposed housekeeping amendments to the Act, which are expected to proceed in spring of 2003, will reflect the fact that government funding of insured hospital services is now provided to hospitals through the funding of health authorities.

There were no amendments to the Hospital Insurance Act Regulations in 2001-2002.

In 2001-2002, the total funding provided to Health Authorities was $5.4 billion, including funds for hospital, continuing care, public and preventive health, and adult mental health programs. Payments to out-of-province hospitals within Canada for insured services (both in-patient and out-patient) provided to British Columbia residents totalled $51.5 million, while payment to hospitals outside the country totalled $9.4 million in 2001-2002.

6.0 Recognition

Funding provided by the federal government through the Canada Health and Social Transfer has been recognized and reported by the Government of British Columbia through various government websites and provincial government documents. For the fiscal year 2001-2002, these documents included the following:

- ☐ Public Accounts for 2000-2001 (Tabled July 31, 2001);
- ☐ Public Accounts for 2001-2002 (Tabled July 11, 2002);
- ☐ Budget and Fiscal Plan, 2002/03 to 2004/05 (Tabled February 19, 2002);
- ☐ Estimates, Fiscal Year Ending March 31, 2003 (Tabled February 19, 2003).

7.0 Extended Health Care Services (EHCS)

The Performance and Management Improvement Division of the Ministry of Health Services funds and provides a comprehensive range of community-based supportive care services to assist people whose ability to function independently is affected by long term health-related problems or who have acute care needs that can be met at home. Services include case management; in-home support services (home support, community home care nursing, physiotherapy, occupational therapy, nutrition counselling, social worker services, and meals programs); residential care services (family care homes, group homes, intermediate and multi-level care homes, private hospitals, extended-care units); community palliative care; residential hospice; and special support services (adult day centres, respite care, and assessment and treatment centres). Services are delivered at the community level through the health authorities.

Residential care services provide care and supervision in a protective, supportive environment for adults who can no longer be looked after in their own homes.

Community home care nursing services provide professional nursing care to people of all ages in their own homes. These services are available on a non-emergency basis and include assessment, teaching and consultation, care coordination, and direct nursing care for clients with chronic, acute, palliative or rehabilitative needs.

Home support services provide assistance with activities of daily living and personal care. Adult day centres offer a centre-based program of health, social and recreational activities.

A Palliative Care Benefits Program was implemented in 2001 to provide home-based palliative care clients with medication for pain and symptom relief, and medical supplies and equipment, at no charge.

Yukon

Introduction

The health care insurance plans operated by the Government of the Yukon Territory are the Yukon Health Care Insurance Plan (YHCIP) and the Yukon Hospital Insurance Services Plan (YHISP). The Yukon Health Care Insurance Plan is administered by the Director, as appointed by the Executive Council Member (Minister). The Yukon Hospital Insurance Services Plan is administered by the Administrator, as appointed by the Commissioner in Executive Council (Commissioner of the Yukon Territory). The Director of the YHCIP and the Administrator of the YHISP are hereafter referred to as the Director, Insured Health and Hearing Services. References in this text to the "Plan" refer to either the Yukon Health Care Insurance Plan or the Yukon Hospital Insurance Services Plan. There are no regional health boards in the Territory.

The objective of the Yukon health care system is to ensure access to, and portability of, insured physician and hospital services in accordance with the provisions of the *Health Care Insurance Plan Act* and the *Hospital Insurance Services Act*. Coverage is provided to all eligible residents of the Yukon Territory on uniform terms and conditions. The Minister, Department of Health and Social Services, is responsible for the delivery of all insured health care services. Service delivery is administered centrally by the Department of Health and Social Services. There were 31,036 eligible persons registered with the Yukon health care plan on March 31, 2002.

Other insured services provided to eligible Yukon residents include the Travel for Medical Treatment Program; Chronic Disease and Disability Benefits Program; Pharmacare and Extended Benefits Programs; and the Children's Drug and Optical Program. Other non-insured health service programs include Continuing Care, Community Nursing, Community Health, and Mental Health Services.

Recent health care initiatives in the Territory target various issues such as rural and remote access to services, nursing and physician recruitment and retention, primary health care, systems development and alternative payment and service delivery systems. A project to implement telehealth links to rural areas has been approved in conjunction with the Canada Health Infostructure Partnerships Program. A second proposal is being developed in conjunction with Health Canada's Primary Health Care Initiative.

The 2001-2002 budget increased/decreased health care expenditures over the 2000-2001 forecast as follows:

- Insured Health Services increased by $1,452,000 or 2.2 percent.
- Yukon Hospital Services increased by $909,000 or 4.5 percent.
- Continuing Care increased by $490,000 or 4.1 percent.
- Community Nursing increased by $220,000 or 2.5 percent.
- Community Health decreased by $34,000 or 0.5 percent.
- Mental Health Services increased by $53,000 or 3 percent.

Some of the major challenges facing the advancement of insured health care service delivery in the Territory are:

- effectively link and co-ordinate existing services and service providers;
- recruitment and retention of qualified health care professionals;
- increasing costs related to service delivery, for example pharmaceuticals, facilities and labour;
- increasing cost to maintain and administer insured health services and extended benefit programs; and
- acquiring and maintaining new and advanced high-technology diagnostic and treatment equipment.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The *Health Care Insurance Plan Act*, adopted April 1, 1972, sets out the legislative framework for the payment of insured physician services to eligible Yukon residents. The *Hospital Insurance Services Act*, adopted April 9, 1960, sets out the legislative framework for payment to hospitals, i.e., amounts in respect of the cost of insured services provided by hospitals to insured persons.

Subject to the *Health Care Insurance Plan Act*, (section 5) and Regulations, the mandate and function of the Director, Insured Health and Hearing Services is to:

- develop and administer the Plan;
- determine eligibility for entitlement to insured health services;
- register persons in the Plan;
- make payments under the Plan, including the determination of eligibility and amounts;
- determine the amounts payable for insured health services outside the Yukon;
- establish advisory committees and appoint individuals to advise or assist in the operation of the Plan;
- conduct actions and negotiate settlements in the exercise of the Government of the Yukon's right of subrogation under this Act to the rights of insured persons;
- conduct surveys and research programs and obtain statistics for such purposes;
- establish what information is required under this Act and the form such information must take;
- appoint inspectors and auditors to examine and obtain information from medical records, reports and accounts; and
- perform such other functions and discharge such other duties as are assigned by the Executive Council Member under this Act.

There were no amendments made to the legislation in 2001-2002.

Subject to the *Hospital Insurance Services Act* (section 6) and Regulations, the mandate and function of the Director, Insured Health and Hearing Services is to:

- develop and administer the hospital insurance plan;
- determine eligibility for and entitlement to insured services;
- determine the amounts that may be paid for the cost of insured services provided to insured persons;
- enter into agreements on behalf of the Government of the Yukon with hospitals in or outside the Yukon, or with the Government of Canada or any province or an appropriate agency thereof, for the provision of insured services to insured persons;
- approve hospitals for purposes of this Act;
- conduct surveys and research programs and obtain statistics for such purposes;
- appoint inspectors and auditors to examine and obtain information from hospital records, reports and accounts;
- prescribe the forms and records necessary to carry out the provisions of this Act; and
- perform such other functions and discharge such other duties as may be assigned by the Regulations.

There were no amendments made to the legislation in 2001-2002.

1.2 Reporting Relationship

Section 6 of the *Health Care Insurance Plan Act* and section 7 of the *Hospital Insurance Services Act* require that the Director, Insured Health and Hearing Services make an annual report to the Executive Council Member respecting the administration of the two health insurance plans. A Statement of Revenue and Expenditures is tabled in the Legislature and is subject to discussion at that level.

The Statement of Revenue and Expenditures for the health care insurance programs of the Health Services Branch is tabled annually in the fall session of the Legislature. The report to be tabled December 2002 covers the fiscal years 1997-1998 to 2001-2002.

1.3 Audit of Accounts

The Health Care Insurance Plan and the Hospital Insurance Services Plan are subject to audit by the Office of the Auditor General of Canada. The Auditor General of Canada is the auditor of the Government of the Yukon in accordance with section 30 of the *Yukon Act* (Canada). The Auditor General is required to conduct an annual audit of the transactions and consolidated financial statements of the Government of the Yukon. Further, the Auditor General of Canada is to report to the Yukon Legislative Assembly any matter falling within the scope of the audit that, in his or her opinion, should be reported to the Assembly.

The most recent audit was for the year ended March 31, 2002.

With regard to the Yukon Hospital Corporation, section 11(2) of the *Hospital Act* requires every hospital to submit a "report of the operations of the Corporation for that fiscal year, the report to include the financial statements of the Corporation and the auditor's report". The report is to be provided to the Department of Health and Social Services within six months of the end of each fiscal year.

1.4 Designated Agency

The Yukon Health Care Insurance Plan has no other designated agencies authorized to receive monies or issue payments pursuant to the *Health Care Insurance Plan Act* or the *Hospital Insurance Services Act*.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Adopted on April 9, 1960, the *Hospital Insurance Services Act*, sections 3, 4, 5 and 9 and sections 2, 4, 5, 9 and 11 of the Hospital Insurance Services Regulations, establish authority to provide insured hospital services. There were no amendments made to the legislation in 2001-2002.

In 2001-2002, insured hospital services to both in- and out-patients were delivered in 15 facilities throughout the Territory. These facilities include one general hospital, one cottage hospital[1] and 12 Health Centres[2]. Visiting nursing services are provided in one satellite health station[3].

Adopted on December 7, 1989, the *Hospital Act* establishes the responsibility of the Legislature and the Government to ensure "compliance with appropriate methods of operation and standards of facilities and care". Adopted on November 11, 1994 the *Hospital Standards Regulation* sets out the conditions under which all hospitals in the Territory are to operate. Section 4(1) provides for the Ministerial appointment of one or more investigators to report on the management and administration of a hospital. Section 4(2) requires that the hospital's Board of Trustees establish and maintain a quality assurance program. Currently, the Yukon Hospital Corporation is operated under a full three-year accreditation through the Canadian Council on Health Services Accreditation.

The Yukon government assumed responsibility for the operation of Health Centres from the federal government in April 1997. These facilities, including the Watson Lake Cottage Hospital, operate in compliance with the adopted Medical Services Branch Scope of Practice for Community Health Nurses/Nursing Station Facility/Health Centre Treatment Facility, and the Community Health Nurse Scope of Practice. The General Duty Nurse Scope of Practice was completed and implemented in February 2002.

Pursuant to the Hospital Insurance Services Regulations, sections 2(e) and (f), services provided in an approved hospital are insured. Section 2(e) defines "in-patient insured services" as all of the following services to in-patients, namely:

- ❑ accommodation and meals at the standard or public ward level;

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[1] This facility provides 24-hour emergency treatment, short-term admissions and respite care.

[2] Community Nurse Practitioners, in the absence of a physician, provide daily clinics for medical treatment, community health programs and 24-hour emergency services.

[3] Community Nurse Practitioners provide itinerant services on a regularly scheduled basis.

- ❑ necessary nursing services;
- ❑ laboratory, radiological and other diagnostic procedures together with the necessary interpretations for the purpose of maintaining health, preventing disease and assisting in the diagnosis and treatment of an injury, illness or disability;
- ❑ drugs, biologicals and related preparations as provided in Schedule B of the Regulations, when administered in the hospital;
- ❑ use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies;
- ❑ routine surgical supplies;
- ❑ use of radiotherapy facilities where available;
- ❑ use of physiotherapy facilities where available; and
- ❑ services rendered by persons who receive remuneration therefor from the hospital.

Section 2(f) of the same Regulations defines "out-patient insured services" as all of the following services to out-patients, when used for emergency diagnosis or treatment within 24 hours of an accident, which period may be extended by the Administrator, provided the service could not be obtained within 24 hours of the accident, namely:

- ❑ necessary nursing services;
- ❑ laboratory, radiological and other diagnostic procedures, together with the necessary interpretations for the purpose of assisting in the diagnosis and treatment of an injury;
- ❑ drugs, biologicals and related preparations as provided in Schedule B, when administered in a hospital;
- ❑ use of operating room and anaesthetic facilities, including necessary equipment and supplies;
- ❑ routine surgical supplies;
- ❑ services rendered by persons who receive remuneration therefor from the hospital;
- ❑ use of radiotherapy facilities where available; and
- ❑ use of physiotherapy facilities where available.

Pursuant to the Hospital Insurance Services Regulation all in and out-patient services provided in an approved hospital by hospital employees are insured services. Standard nursing care, pharmaceuticals, supplies, diagnostic and operating services are provided. Any new programs or enhancements with significant funding implications or reductions to services or programs require the prior approval of the Minister, Department of Health and Social Services. This process is managed by the Director Insured Health and Hearing Services. Public representation regarding changes in service levels is made through membership on the hospital board. No new services were added or discontinued in 2001-2002.

2.2 Insured Physician Services

Adopted on April 1, 1972, sections 1 to 8 of the *Health Care Insurance Plan Act* and sections 2, 3, 4, 7,10 and 13 of the Health Care Insurance Plan Regulations provide for insured physician services. There were no amendments made to the legislation in 2001-2002.

The Yukon Health Care Insurance Plan covers physicians providing medically required services. The conditions a physician must meet to participate in the Yukon Health Care Insurance Plan are to:

- ❑ register for licensure pursuant to the *Medical Professions Act*, and
- ❑ maintain licensure pursuant to the *Medical Professions Act*.

The number of resident physicians participating in the Yukon Health Care Insurance Plan as of March 31, 2002 was 54.

Section 7(5) of the Yukon Health Care Insurance Plan Regulations states that "A medical practitioner may elect to collect his fees under the Plan for insured services rendered to insured persons otherwise than from the Plan without loss of benefit to insured persons by giving notice in writing of his election". In 2001-2002, no physicians provided written notice of their election to collect fees other than from the Yukon Health Care Insurance Plan.

Insured physician services in the Yukon are defined as medically required services rendered by a medical practitioner. Services not insured by the Plan are listed in section 3 of the Regulations (see section 2.4). Services not covered by the Plan include advice by telephone, medical-legal services, preparation of records and reports, services required by a third party, cosmetic services, and services determined to be not medically required.

From April 1, 2001 to March 31, 2002 the following services were added to the list of insured physician services covered by the Yukon Health Care Insurance Plan:

- ☐ Zenkers Diverticulotomy (fee code 7555)
- ☐ Rheumatology – Consultation (fee code T3310)
- ☐ Rheumatology – Repeat or Limited Consultation (fee code T3312)
- ☐ Rheumatology – Prolonged Visit for Counselling (fee code T3314)

The process used to add a physician service to the list of insured services covered by the Yukon Health Care Insurance Plan requires that physicians submit in writing a request to have a fee code added to the Relative Value Guide to Fees[4]. The request is then reviewed by the Yukon Health Care Insurance Plan/Yukon Medical Association Liaison Committee. Following this review, a decision is made on whether to include or exclude the service. The costs or fees are normally set in accordance with similar costs or fees in other jurisdictions. Once a fee-for-service value has been determined, notification of the service and the applicable fee is provided to all Yukon physicians. Alternatively new fees can be implemented as a result of the fee negotiation process between the Yukon Medical Association and the Department of Health and Social Services. The Director, Insured Health and Hearing Services manages this process and no public consultation is required.

2.3 Insured Surgical-Dental Services

Dentists providing insured surgical-dental services under the health care insurance plan of the Territory must be licensed pursuant to the *Dental Professions Act* and are provided billing numbers for the purpose of billing the Yukon Health Care Insurance Plan for the provision of insured dental services. In 2001-2002, six dentists, three oral surgeons and two orthodontists billed the Plan for insured dental services provided to Yukon residents. No dentists opted out of the Yukon Health Care Insurance Plan in 2001-2002.

Insured dental services are limited to those surgical-dental procedures listed in Schedule "B" of the Regulations and require the unique capabilities of a hospital for their performance (e.g., surgical correction of prognathism or micrognathia). Insured surgical-dental services include:

- ☐ surgical removal of unerupted teeth;
- ☐ alveoloplasty and gingivolplasty;
- ☐ sulcus deepening and ridge construction;
- ☐ exposure of tooth for orthodontic treatment;
- ☐ treatment of traumatic injuries to soft tissues within the mouth;
- ☐ root resection;
- ☐ phrenectomy;
- ☐ excision of intra-oral cysts;
- ☐ excision of benign intra-oral tumours;
- ☐ sialolithotomy;
- ☐ excision of ranula;
- ☐ condylectomy;
- ☐ intra-oral biopsy;
- ☐ incision and drainage of abscess of dental origin;
- ☐ closed reduction of fractures of mandible and maxilla;
- ☐ open reductions of fractures of mandible and maxilla;
- ☐ closed reduction of temporo-mandibular dislocation;
- ☐ open reduction of temporo-mandibular dislocation;

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[4] Physician's fee guide manual.

- removal of root or foreign body from maxillary antrum;
- repair and closure of antro-oral fistula;
- surgical correction of prognathism or micrognathia;
- therapeutic or diagnostic alcohol nerve block; and
- avulsion of nerve (mental, infra-orbital or interior dental).

In the case of children aged 16 years or under, the following surgical-dental services are also insured:

- oral surgery and orthodontia necessitated by, or consequent to the repair of, cleft palate or cleft lip deformity, only where that service arises as part of or following plastic surgical repair;
- surgical removal of erupted, unerupted or impacted teeth; and
- such other dental care procedures determined medically necessary by the Director, Insured Health and Hearing Services.

The addition or deletion of new surgical-dental services to the list of insured services requires amendment by Order-in-Council to Schedule B of the Regulations Respecting Health Care Insurance Services. Coverage decisions are made on the basis of whether or not the service must be provided in hospital under general anaesthesia. The Director, Insured Health and Hearing Services administers this process.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Only services prescribed by and rendered in accordance with the *Health Care Insurance Plan Act* and Regulations and the *Hospital Insurance Services Act* and Regulations are insured. All other services are uninsured. See "Additional Materials" for a complete listing.

Uninsured physician services include:

- services that are not medically necessary;
- charges for long-distance telephone calls;
- preparing or providing a drug;
- advice by telephone at the request of the insured person;
- medico-legal services including examinations and reports;
- cosmetic services;
- acupuncture;
- experimental procedures.

Section 3 of the Yukon Health Care Insurance Plan Regulations contains a non-exhaustive list of services that are prescribed as non-insured.

Uninsured hospital services include:

- non-resident hospital stays;
- special/private nurses requested by the patient or family;
- additional charges for preferred accommodation unless prescribed by a physician;
- crutches and other such appliances;
- nursing home charges;
- televisions;
- telephones; and,
- drugs and biologicals following discharge. (These services are not provided by the hospital.)

Uninsured dental services include:

- procedures considered restorative;
- procedures that are not performed in a hospital under general anaesthesia.

All Yukon residents have equal access to services. Third parties such as private insurers or the Workers' Compensation Health and Safety Board do not receive priority access to services through additional payment. The Territory has no formal process to monitor compliance; however, feedback from physicians, hospital administrators, medical professionals and staff allows the Director, Insured Health and Hearing Services to monitor usage and service concerns.

The purchase of non-insured services such as fibreglass casts does not delay or prevent access to insured services at any time. Insured persons are provided treatment options at the time of service. The Territory has no formal process to monitor compliance; however, feedback from physicians, hospital administrators, medical professionals and staff allows the Director, Insured Health and Hearing Services to monitor usage and service concerns.

Physicians in the Territory may bill patients directly for non-insured services. Block fees are not used at this time; however some do bill by service item. Billable services include, but are not limited to completion of employment forms, medical legal reports, transferring records, third party examinations, some elective services, tray fees and telephone prescriptions, advice or counselling. Payment does not affect patient access to services as not all physicians or clinics bill for these services and other agencies or employers may cover the cost.

The process used to de-insure services covered by the Yukon Health Insurance Plan is as follows:

- ☐ **Physician services** - the Yukon Health Care Insurance Plan/Yukon Medical Association Liaison Committee is responsible for reviewing changes to the Relative Value Guide to Fees, including decisions to de-insure certain services. In consultation with the Yukon Medical Advisor, decisions to de-insure services are based on medical evidence that indicates the service is not medically necessary, ineffective or a potential risk to the patient's health. Once a decision has been made to de-insure a service all physicians are provided notification in writing. The Director, Insured Health and Hearing Services manages this process.

  The following service was removed from the Relative Value Guide to Fees in fiscal year 2001-2002.

  Anaesthetic – Nerve Root Facet Block (fee code 1041)

- ☐ **Hospital services** - an amendment by Order-In-Council to section 2 (e)(f) of the Yukon Hospital Insurance Services Regulations would be required. As of March 31, 2001, no insured in-patient or out-patient hospital services, as provided for in the Regulations, have been de-insured. The Director, Insured Health and Hearing Services is responsible for managing this process in conjunction with the Yukon Hospital Corporation.

- ☐ **Dental-surgical services** - an amendment by Order-In-Council to Schedule B of the Regulations Respecting Health Care Insurance Services is required. A service could be de-insured if determined not medically necessary or if it is no longer required to be carried out in a hospital under general anaesthesia. The Director, Insured Health and Hearing Services manages this process.

3.0 Universality

3.1 Eligibility

Eligibility requirements for insured health services are set out in the *Health Care Insurance Plan Act and Regulations*, sections 2 and 4 respectively and the *Hospital Insurance Services Act and Regulations*, section 2 and 4 respectively. Subject to the provisions of these Acts and Regulations, every Yukon resident is eligible for and entitled to insured health services on uniform terms and conditions. The term "resident" is defined using the wording of the *Canada Health Act* and "means a person lawfully entitled to be or to remain in Canada, who makes his home and is ordinarily present in the Yukon, but does not include a tourist, transient or visitor to the Yukon." Where applicable, the eligibility of all persons is administered in accordance with the Inter-provincial Agreement on Eligibility and Portability.

Under section 4.(1) of both Regulations "an insured person is eligible for and entitled to insured services after midnight on the last day of the second month following the month of arrival to the Territory." No changes affecting eligibility were made to the legislation in 2001-2002.

Residents ineligible for coverage are those residents who are entitled to or eligible for benefits under any other Act, under any law of a province or under any Act of the Canadian Parliament other than the *Canada Health Act*. This includes but is not limited to visitors to the Territory, persons eligible for coverage from their home province or territory for the period of their stay, refugees, members of the Canadian Forces; members of the Royal Canadian

Mounted Police (RCMP); inmates in federal penitentiaries, Study Permit holders and persons with Employment Authorizations of less than one year.

People who provide documentation indicating the date of discharge or release from the RCMP, armed forces or a federal penitentiary become eligible for coverage under the Yukon Health Care Insurance Plan on the day following the documented date.

3.2 Registration Requirements

Section 16 of the *Health Care Insurance Plan Act* states: "Every resident other than a dependant or a person exempted by the Regulations from so doing, shall register himself and his dependants with the Director, Insured Health and Hearing Services, at the place and in the manner and form and at the times prescribed by the Regulations." Registration is administered in accordance with the Inter-provincial Agreement on Eligibility and Portability.

Persons and dependants under the age of 19 who move permanently to the Yukon are advised to apply for health care insurance upon arrival. Application is made by completing a registration form available from the Insured Health and Hearing Services office or community Territorial Agents. Once coverage is effective, a health care card is issued. Family members receive separate health care cards and numbers. Health care cards expire every year on the resident's birthday and an updated label with the new expiry date is mailed out accordingly.

If other family members move to the Yukon in advance of a remaining spouse residing elsewhere in Canada, the originating province or territory will cover all family members to a maximum of 12 months.

As of March 31, 2002, there were 31,036 residents registered with the Yukon Health Care Insurance Plan.

3.3 Other Categories of Individual

The Yukon Health Care Insurance Plan provides health care coverage for other categories of individuals as follows:

Returning Canadians	No waiting period is applied
Landed Immigrants	No waiting period is applied.
Minister's Permit	No waiting period is applied if authorized
Convention Refugees	No waiting period is applied if holding Employment Authorization*
Foreign Workers	No waiting period is applied if holding Employment Authorization*
Clergy	No waiting period is applied if holding Employment Authorization*
* Employment Authorization must be in excess of twelve months	

The estimated number of new individuals receiving coverage in the Yukon during 2001-2002 under the following conditions is:

Returning Canadians	23
Landed Immigrants	35
Ministers Permit	0
Convention Refugees	0

The estimated number of individuals receiving coverage in the Yukon as of March 31, 2002, under the following conditions is:

Foreign Workers	40
Clergy	0

3.4 Premiums

Yukon residents pay no premiums.

4.0 Portability

4.1 Minimum Waiting Period

Persons moving to the Yukon from another province or territory are entitled to coverage pursuant to section 4(1) of the Yukon Health Care Insurance Plan Regulations and the Yukon Hospital Insurance Services Regulations. The Regulation states that "an insured person is eligible for and entitled to insured services after midnight on the last day of the second month following the month of arrival to the Territory".

4.2 Coverage During Temporary Absences In Canada

The provisions relating to portability of health care insurance during temporary absences in Canada are defined in sections 5, 6, 7 and 10 of the Yukon Health Care Insurance Plan Regulations and sections 6, 7(1), 7(2), and 9 of the Yukon Hospital Insurance Services Regulations.

The Regulations state that "where an insured person is absent from the Territory and intends to return, he is entitled to insured services during a period of 12 months continuous absence." Persons leaving the Territory for a period exceeding two months are advised to contact the Yukon Health Care Insurance Plan and complete a form of "Temporary Absence". Failure to do so may result in the cancellation of coverage.

Students attending educational institutions outside the Territory remain eligible for the duration of their academic studies. The Director, Insured Health and Hearing Services may approve other absences in excess of 12 continuous months upon receipt of a written request from the insured person. Requests for extensions must be renewed yearly and are subject to approval by the Director.

For temporary workers and missionaries, the Director, Insured Health and Hearing Services may approve absences in excess of 12 continuous months upon receipt of a written request from the insured person. Requests for extensions must be renewed yearly and are subject to approval by the Director, Insured Health and Hearing Services.

The provisions regarding coverage during temporary absences in Canada fully comply with the terms and conditions of the Inter-provincial Agreement on Eligibility and Portability effective January 1, 1998. Definitions are consistent in Regulations, policies and procedures.

The Yukon participates fully with the Inter-provincial Medical Reciprocal Billing Agreements and Hospital Reciprocal Billing Agreements in place with all other provinces and territories (Quebec does not participate in the medical reciprocal billing arrangement). Insured services provided to Yukon residents while temporarily absent from the Territory are paid at the rates established by the host province. The following amounts were paid to out-of-territory hospitals for the fiscal year 2001-2002.

In-patient services	Out-patient services
$4,263,271	$938,871

Note: Figures are by date of service and subject to adjustment

In 2001-2002 payments to out-of-territory physicians totalled $1,601,642. This figure includes out-of-Canada costs and is by payment date.[5]

The Hospital Reciprocal Billing Agreements provide for payment of in-patient and out-patient hospital services to eligible Yukon residents receiving insured services outside the Territory. High-cost procedure rates, newborn rates and out-patient rates are established by the Federal/Provincial/Territorial Coordinating Committee on Reciprocal Billing. These rates are established by Order-in-Council under the Charges for Out-Patient Procedures Regulation, Standard Ward Rates Regulation and Charges for In-Patient High-Cost Procedures Regulation.

The Medical Reciprocal Billing Agreements provide for payment of insured physician services on behalf of eligible Yukon residents receiving insured services outside the Territory. Payment is made to the host province at the rates established by that province.

4.3 Coverage During Temporary Absences Outside Canada

The provisions that define portability of health care insurance to insured persons during temporary absences outside Canada are defined in sections 5, 6, 7, 9, 10 and 11 of the Yukon Health Care Insurance Plan Regulations and sections 6, 7(1), 7(2) and 9 of the Yukon Hospital Insurance Services Regulations.

Sections 5 and 6 state that "Where an insured person is absent from the Territory and intends to return, he is entitled to insured services during a period of 12 months' continuous absence."

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[5] Out-of-country costs are reported under lines 22 and 23 in the Yukon section of Annex A – Provincial and Territorial Health Care Insurance Plan Statistics.

The provisions for portability of health insurance during out-of-country absences are similar to those in effect for absences within Canada as described under section 4.2. Similar provisions are applied to out-of-country students, temporary workers and missionaries.

Persons leaving the Territory for a period exceeding two months are advised to contact the Yukon Health Care Insurance Plan and complete a form of "Temporary Absence". Failure to do so may result in the cancellation of coverage.

Students attending educational institutions outside the Territory remain eligible for the duration of their academic studies. With regard to temporary workers and missionaries, the Director, Insured Health and Hearing Services may approve absences in excess of 12 continuous months upon receipt of a written request from the insured person. All requests for extensions must be renewed yearly and are subject to approval by the Director, Insured Health and Hearing Services.

Insured physician services provided to eligible Yukon residents temporarily outside the country are paid at rates equivalent to those paid had the service been provided in the Yukon. Reimbursement is made to the insured person by the Yukon Health Care Insurance Plan or directly to the provider of the insured service.

Insured in-patient hospital services provided to eligible Yukon residents outside Canada are paid at the rate established in the Standard Ward Rates Regulation for the Whitehorse General Hospital. The standard ward rate for the Whitehorse General Hospital as of March 31, 2002 was $989. The rate is established through Order-in-Council and is derived as follows:

- Standard Ward Rate = (total operating expenses - non-related in-patient costs - related newborn costs - associated out-patient costs) / (total patient days - patient days for other services, ex. non-Canadians).

Insured out-patient hospital services provided to eligible Yukon residents outside Canada are paid at the rate established in the Charges for Out-Patient Procedures Regulation. The out-patient rate is currently $110 and is established through Order-in-Council and derived by the Canadian Co-ordinating Committee on Reciprocal Billing (CCRB).

The following amounts were paid in 2001-2002 for elective and emergency services provided to eligible Yukon residents outside Canada:

In-patient services	Out-patient services
$48,621	$4,321

Note: Figures are by service date and subject to adjustment

4.4 Prior Approval Requirement

There is no legislated requirement that eligible residents must seek prior approval before seeking elective or emergency hospital or physician services outside Canada. Eligible persons are reimbursed the standard ward rate and physican fees for these services.

5.0 Accessibility

5.1 Access to Insured Health Services

There are no user fees or co-insurance charges under the Yukon Health Care Insurance Plan or the Yukon Hospital Insurance Services Plan. Uniform access to specialists and services not available locally are available through a visiting medical specialist program and a publicly funded travel for medical treatment program. There is no extra-billing in the Yukon for any services covered by the Plan.

5.2 Access to Insured Hospital Services

Pursuant to the *Hospital Act*, the "Legislature and Government have responsibility to ensure the availability of necessary hospital facilities and programs". Based on the population of the Yukon the current number of hospital beds is considered sufficient.

As the only major acute care hospital facility in the Territory the Whitehorse General Hospital is responsible for determining the number of beds available. Decisions on the number of beds are made based on utilization and staffing compliments. The determination of the number of beds available at the Watson Lake Cottage

Hospital are made in conjunction with Community Nursing based on utilization and staffing compliments. The Minister must approve any significant changes to the level of service delivery.

Acute-care beds are readily available and no wait-list for admission exists. The Yukon's main acute-care facility, the Whitehorse General Hospital, is located in Whitehorse. There were 49 beds staffed and in operation as of March 31, 2002. Eight additional acute-care beds can be made available, should future occupancy trends indicate a need. The Yukon has no rehabilitative beds. Patients are referred out-of-territory for these services – usually to Vancouver or Edmonton. (For additional information on the number and type of hospital beds in the Yukon see the related Statistical Annex, items 3 and 4.)

The Whitehorse General Hospital currently employs 103 nurses, representing 72¾ full-time equivalent (FTE) positions. A full complement requires 75¾ FTE positions. The shortfall in staff is covered by casual and term employees.

The Whitehorse General Hospital provides in-patient, out-patient, and 24-hour emergency services. Emergency services are provided on rotation by local physicians. Medical services provided include:

- intensive care services (surgical and cardiac);
- respiratory services (chronic obstructive pulmonary diseases, asthma etc.);
- cardiovascular accidents;
- maternity;
- gastrosintestinal bleeds;
- cellulitis;
- chemotherapy;
- hypertension, and
- general failure to thrive/weakness.

Surgical services provided include:

- minor orthopaedics;
- selected major orthopaedics;
- gynecology;
- paediatrics;
- general abdominal;
- mastectomy;
- emergency trauma;
- ear/nose/throat/otolaryngology;
- ophthalmology including cataracts.

Patients requiring specialized surgeries are sent to outside centres.

Diagnostic services include:

- radiology;
- laboratory;
- mammography, and
- electrocardiogram.

Selected rehabilitative services are available through out-patient therapies.

There is no wait-list for admission to the Whitehorse General Hospital. Emergency surgery patients are normally seen within 24 hours. Elective surgery patients are normally seen within one to two weeks. The number of Visiting Specialist clinics is routinely adjusted to address wait times, particularly for orthopaedics, ear/nose/throat and ophthalmology (see section 5.3).

A second acute care facility is located at the Watson Lake Cottage Hospital. This facility has 12 beds and there is no wait-list for admission.

Other than the Whitehorse General Hospital and the Watson Lake Cottage Hospital, only the Dawson Health Centre provides limited in-patient services. Out-patient and 24-hour emergency services are provided by 12 Community Health Centres. Health Centres are staffed by one or more Community Nurse Practitioners and auxiliary staff. The communities of Whitehorse, Faro, Mayo, Watson Lake and Dawson City have resident physicians.

A number of measures have been taken to improve access to insured hospital services.

- In fall 2000, a Technical Review Committee was struck for the purpose of making recommendations as required to the Department of Health and Social Services on health programs and services in the Yukon. Their mandate is to develop criteria for the initiation, elimination, expansion or reduction of health programs or services. These criteria include, the minimum number of patients needed to provide effective, safe care; health human resource requirements, including the need for specialized nurses, physicians, biomedical technicians etc., other resource requirements, including space, equipment, infrastructure support, etc., and cost effectiveness. Resulting decisions on equipment or service capacity do not impede access to medically necessary services as existing services and programs continue to provide access. (This committee meets on an ad hoc basis.)

❑ Based on the success of the 1998 pilot project, application for funding was made to the Canada Health Infostructure Partnerships Program (CHIPP), to implement real-time video to support access and delivery of services between outlying rural communities with Whitehorse, and Whitehorse with outside centres in British Columbia or Alberta. CHIPP approved $1 million in funding for this project, which will run from September 1, 2001 to March 31, 2003.

Through this funding, telehealth has been implemented in Whitehorse and five rural Yukon communities. Implementation was completed in May 2002 and application has since been made to CHIPP to extend the project completion date from March 31, 2003 to September 30, 2003. An extension of the project will ensure that sufficient data is collected to adequately evaluate the project. To date tele-mentalhealth sessions have occurred between Whitehorse and rural Yukon as well as between Whitehorse and British Columbia psychiatrists. Since implementation there have been two to four tele-education sessions each month provided from Whitehorse to the rural sites. These sessions have been attended by physicians, nurses, social workers, mental health counsellors and allied professionals such a CHR's and First Nation Wellness workers.

The Department of Health and Social Services continues to work with the Yukon Hospital Corporation and Community Nursing to ensure the current waiting time for insured hospital services in the Territory is maintained at existing levels or reduced. For example, the Department has initiated the following project to reduce the wait time for services:

❑ In January 2002 it was announced that $1,500,000 was budgeted for the purchase of a Computed Tomography Scanner, related equipment and staffing for the Whitehorse General Hospital. While not planned to be operational until fall 2002-2003 it will reduce the need for residents to travel outside the Territory to access this service.

5.3 Access to Insured Physician and Dental-Surgical Services

Existing legislation and administration of services provides all eligible Yukon residents with equal access to insured physician and dental services on uniform terms and conditions.

Most physicians in the Yukon are located in Whitehorse. Outside Whitehorse only two rural communities have resident fee-for-service physicians: Dawson City and Watson Lake. Two contracted physicians also provided resident services in Faro and Mayo.

A visiting physician program provides access to insured physician services to 10 rural and remote locations. The frequency of visiting clinics is based on demand and utilization. Physicians who provide visiting services are compensated under contract for lost practice time, mileage, meals and accommodation, in addition to a sessional rate *or* fee-for-service billings.

Outside the usual distribution of physicians and specialists in the Territory, uniform access to insured physician and dental services is further ensured through the Travel for Medical Treatment Program. This program covers the cost of medically necessary transportation, allowing eligible persons to access services not available in their home communities. Eligible persons are routinely sent to Whitehorse, Vancouver, Edmonton or Calgary to receive services.

In addition, the Visiting Specialist Program provides local access at the Whitehorse General Hospital, Mental Health Services or the Yukon Communicable Disease Unit to specialist services not regularly available in the Territory.

The following resident physicians, specialists and dentists provided services in the Yukon as of March 31, 2002: (See Statistical Annex item #30.)

General Practitioners/Family Practitioners	49
Specialists	5
Dentists	11

The following specialists provide services under the Visiting Specialist Program:

Ophthalmology	1
Oncology	3
Orthopaedics	4
Internal Medicine	1
Otolaryngology	2
Neurology	1
Rheumatology	1
Dermatology	1
Dental Surgery*	1
Infectious Disease*	1
Psychiatry*	3

* Note Services not provided through the Visiting Specialist as administered by the Whitehorse General Hospital

Visiting Specialist clinics are held between one and eight times per year depending on demand and availability of specialists. As of March 31, 2002, the wait-list for non-emergency specialist services was estimated at:

Ophthalmology	0-3 months
Orthopaedics	2-13 months
Otolaryngology	5-12 months
Neurology	3-6 months
Rheumatology	2-6 months
Dental Surgery*	2-3 months

* Note Services not provided through the Visiting Specialist as administered by the Whitehorse General Hospital

The Department of Health and Social Services has taken several measures to reduce waiting times for insured physician services. A variety of recruitment and retention initiatives were initiated for 2001-2002 and 2002-2003 to increase the number of resident and locum physicians in the Territory, including:

- ☐ **Resident Support Program**: assists with travel, accommodation and vehicle expenses for residents in a family practice program and for medical students in the Yukon.
- ☐ **Locum Support Program**: assists with travel and accommodation expenses for physicians providing locum services to resident physicians.
- ☐ **Physician Relocation Fund**: assists with relocation costs for family practice physicians recruited to the Yukon. A return-in-service commitment is required.
- ☐ **Office Start-Up Fund**: assist physicians relocating to the Yukon in an area designated by the Joint Management Committee as requiring additional physician resources.
- ☐ **Education Support Program**: supports Yukon physicians who leave the Territory for specialized training. A return-in-service commitment is required.
- ☐ **Rural Training Fund**: supports rural physicians to maintain emergency skills through specialized course work.
- ☐ **Bursary Program**: targets students entering medical school. A return-in-service commitment is required.

Amendments were made to the *Medical Professions Act* in 2001-2002 to provide for the issuance of special licenses in response to a demonstrated need. The candidate must have already been offered a position in the Territory subject to special licensing and the Minister of Health and Social Services must state in writing that a demonstrated need for the special license exists.

5.4 Physician Compensation

The Department of Health and Social Services seeks its negotiating mandate from the Government of Yukon, prior to entering negotiations with the Yukon Medical Association (YMA). The YMA and the Government each appoint members to the negotiating team. Meetings are held as required until an agreement has been reached. The YMA's negotiating team then seeks approval of the tentative agreement from the YMA membership. The Department of Health and Social Services seeks ratification of the agreement from the Government of Yukon. The final agreement is signed with the concurrence of both parties.

The most recent fee negotiations were concluded on March 26, 2002. The resulting Memorandum of Understanding is effective from

April 1, 2002 through March 31, 2004. The MOU establishes the terms and conditions for payment of the following:

- Fee-for-service physicians;
- Alternative payment physicians;
- Continuing Medical Education;
- Medical Practice Insurance; and,
- Benefit Programs.

The legislation governing payments to physicians and dentists for insured services are the *Health Care Insurance Plan Act* and the Health Care Insurance Plan Regulations. No amendments were made to the legislation in 2001-2002.

The fee-for-service system is used to reimburse the majority of physicians and dentists providing insured services to residents. In 2001-2002, two full-time rural physicians are compensated on a contractual basis and three physicians providing visiting clinics in outlying communities are paid a flat sessional rate for services.

5.5 Payments to Hospitals

The Government of Yukon funds the Yukon Hospital Corporation (Whitehorse General Hospital), through global contribution agreements with the Department of Health and Social Services. Global operations and maintenance (O and M) and capital funding levels are negotiated based on operational requirements and utilization projections for prior years. The current one-year contribution agreement is in effect to March 31, 2003.

In addition to the established O and M and capital funding set out in the agreement, provision is made for the hospital to submit requests for additional funding assistance for implementing new or enhanced programs.

Only the Whitehorse General Hospital is funded directly through a contribution agreement. The cottage hospital and all Health Centres are funded through the Yukon Government's budget process.

The legislation governing payments made by the health care plan to facilities that provide insured hospital services is the *Hospital Insurance Services Plan Act* and Regulations. The legislation and Regulations set out the legislative framework for payment to hospitals for insured services provided by that hospital to insured persons. No amendments were made to the legislation in 2001-2002.

6.0 Recognition Given to Federal Transfers

The Government of the Yukon has acknowledged the federal contributions provided through the Canada Health and Social Transfer (CHST) in its 2001-2002 annual Main Estimates and Public Accounts publications, which are available publicly. Section 3(1)(d)(e) of the *Health Care Insurance Plan Act* and section 3 of the *Hospital Insurance Services Act*, acknowledge the contribution of the Government of Canada. These documents are available to Health Canada as part of the Provision of Additional Materials section.

7.0 Extended Health Care Services

Nursing Home Intermediate Care and Adult Residential Care Services

Extended Health Care Services are available to eligible Yukon residents. In 2001-2002, there were three facilities providing services in the Yukon. These facilities provide one or more of the following services:

- personal care;
- extended care services;
- nursing home intermediate care;
- special care;
- respite;
- day program; and
- out-patient therapy services.

The above services are not provided for in legislation. No major changes were made in the administration of these services in 2001-2002.

In addition to the services described above, the following are also available to eligible Yukon residents outside the requirements of the *Canada Health Act*:

- ***The Chronic Disease and Disability Benefits Program*** provides benefits for eligible Yukon residents who have specific chronic diseases or serious functional disabilities: coverage of related prescription drugs and medical-surgical supplies and equipment. (Chronic Disease and Disability Benefits Regulation)
- ***The Pharmacare Program and Extended Benefits Programs*** are designed to assist registered senior citizens with the cost of prescription drugs, dental care, eye care, hearing services, and medical-surgical supplies and equipment. (Pharmacare Plan Regulation and Extended Health Care Plan Regulation)
- ***The Travel for Medical Treatment Program*** assists eligible Yukon residents with the cost of emergency and non-emergency medically necessary air and ground transportation. (*Travel for Medical Treatment Act* and Travel for Medical Treatment Regulation)
- ***The Children's Drug and Optical Program*** is designed to assist eligible low-income families with the cost of prescription drugs, eye exams and eye glasses for children 18 and younger. (Children's Drug and Optical Program Regulation)
- ***Mental Health Services*** provides assessment, diagnostic, individual and group treatment, consultation and referral services to individuals experiencing a range of mental health problems. (Mental Health Act and Mental Health Act Regulations).
- ***Public Health*** is designed to promote health and well-being throughout the Territory through a variety of preventive and education programs. This is a non-legislated program.
- ***The Ambulance Services Program*** is responsible for the emergency stabilization and transportation of sick and injured persons from an accident scene to the nearest health care facility capable of providing the required level of care. This is a non-legislated program.
- ***Hearing Services*** provides services designed to help people of all ages with a variety of hearing disorders, through the provision of routine and diagnostic hearing evaluations and community outreach. This is a non-legislated program.
- ***Dental Services*** provides a comprehensive diagnostic, prevent and restorative dental service to children from pre-school to grade eight in Whitehorse and Dawson City. All other Yukon communities receive services for pre-school to grade 12. This is a non-legislated program.

Home Care Services

The Yukon Home Care Program provides assessment and treatment, personal support, social support, respite services and palliative care. In Whitehorse, services are provided by home support workers, nurses, social workers and therapists. In rural communities, auxiliary home support workers assist clients with personal care and respite services. Services are available Monday through Friday. In Whitehorse, additional services such as planned weekend and evening support may be provided to 9:00 pm during end-stage palliative care. Twenty-four hour care is not provided.

Ambulatory Health Care Services

The Yukon Home Care Program provides the majority of ambulatory health care services outside institutional settings. Most other services are provided through Community Nursing or public health. All residents have equal access to services.

8.0 Additional Materials Submitted to Health Canada

- Listing of uninsured hospital, physician and surgical-dental services
- Health Care Insurance Plan Act and Regulations (office consolidation of Act)
- *Hospital Insurance Services Act* and Regulations (office consolidation of Act)
- *Medical Professions Act* and Regulations
- *Hospital Act* and Regulations
- *Mental Health Act* and Regulations
- *Dental Professions Act* and Regulations
- Statement of Revenue and Expenditures: Health Care Insurance Programs (1997-1998 to 2001-2002)
- Yukon Public Accounts – Excerpt of the Auditor General's Report, 2001-2002
- Yukon Public Accounts – Excerpt of consolidated Financial Statements, 2000-2001
- Yukon Budget, 2001-2002

Northwest Territories

Introduction

The Northwest Territories (NWT) Department of Health and Social Services, together with nine health and social services authorities, offer a broad range of programs and services in family support, child protection, public health, home care, independent living, community wellness, environmental health, vital statistics, insured services and supplementary health benefits. While insured services include medical care and hospital care, there are a number of other supplementary health benefits that are provided to eligible residents, such as pharmacare, medical travel and extended medical benefits for seniors. The NWT Department of Health and Social Services takes a community-based approach to service delivery. Health and Social Services authorities deliver a full spectrum of community and institutional health services. Nurses are the largest group of health care practitioners in the NWT. In most communities, community health nurses are the access point to health care at community health centres. Health centres provide regular and emergency out-patient treatment services, a full public health program and consultation with physicians as needed. Social workers provide community-based social services, including counselling, crisis intervention and child welfare programs.

In larger communities such as Yellowknife and Inuvik, physicians are often the public's first point of contact with the health care system. Other communities are visited regularly by general practitioners and at times by specialists.

Specialists are based at Stanton Territorial Hospital in Yellowknife, or at hospitals in southern Canada. Stanton resident specialties include obstetrics/gynaecology, internal medicine, paediatrics, orthopaedics, ophthalmology, ear, nose and throat, radiology, general surgery and psychiatry. Special visiting clinics, such as urology and cardiology, offer additional consultant services for patients referred from outlying communities.

Changing Demographics

As of July 1, 2002, there were an estimated 41,403 people[1] in the Northwest Territories, of which 50.7 percent were Aboriginal people. The NWT continues to have a relatively young population and a high birth rate. According to the census, approximately 27.5 percent of the NWT population is under 15 years of age, compared with 19 percent in the overall Canadian population. This population profile supports the continued need to invest in services that target children, youth and young families.

Although the territorial population is comparatively young, it is nonetheless aging. It is expected that in less than 20 years, the number of seniors 65 years of age and older will rise from approximately 1,700 to over 4,400, representing an increase of 160 percent. In contrast, it is expected that the population under 20 years of age will increase by less than 15 percent over the same period. The demand for health resources among seniors is more than five times that of the population under 65. This relates to higher rates of cancer, circulatory diseases, nervous system and sense organ diseases, injuries and respiratory diseases. This growing number of aging residents will also require significant investments in services for the elderly such as home and long-term care.

Changing Economic Conditions

Changes in the economic situation in the North continue to have an impact on the health and well-being of residents. Increased employment opportunities, especially in the areas of mining and oil and gas exploration, are having a positive impact on the economy. With this comes increased disposable income, which can result in improved nutrition, safety, and security for families. However, the changes in economic conditions have also lead to increases in social problems such as abuse of alcohol or gambling.

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[1] The population estimate is from Statistics Canada. Statistics Canada provides a set of population estimates on a quarterly basis for all provinces and territories.

Studies have shown that the unemployed have a reduced life expectancy and suffer more health problems than the employed. In the NWT's smaller communities, low household income levels and reduced employment opportunities combined with overcrowded housing conditions also create stress and unhealthy living conditions. There is also an urbanization process occuring, specifically the migration of individuals and families from smaller communities to regional centres and Yellowknife in search of employment.

Incidence of Preventable Illness, Injury and Death

Compared with the rest of Canada, the incidence of preventable illness, injury and death continue to be high in the Northwest Territories (*1999 Health Status Report*). Adverse outcomes such as family violence, Fetal Alcohol Syndrome/Effects (FAS/E) and most forms of cancer are linked to poor lifestyle choices made by individuals regarding diet or the use of alcohol, tobacco and drugs. Injuries and deaths associated with injuries are often the result of risky behaviour. The underlying causes of many acute or long-term care needs are linked to poverty, low educational achievements, unemployment, and low self-esteem, all of which can lead to poor coping skills.

Even though there is a downward trend in the rest of Canada, tobacco use continues to be a serious public health concern in the NWT. Smoking rates in the NWT are among the highest in Canada. The implications for health care costs and human costs in terms of death and disability are significant and rising.

Increases in Health Care and Social Services Costs

Many factors have led to a continued increase in demand for resources. These factors include, but are not limited to demographics, recruitment and retention of health professionals, new technologies, pharmaceuticals and medical practices, increased incidence of chronic and new diseases, and public expectations. Increasing costs continue to place pressure on the system.

Maintaining a Sustainable System

The delivery of health and social programs remains a subject of ongoing discussion. There are a number of significant issues that place pressure on the sustainability of the system, in particular given limited resources, the continued increase in demands, the capacity of the current system to maintain quality of care, the accountability of the different partners within the system, and challenges related to the coordination of service delivery. Difficulty in recruiting health professionals and the ongoing competition between Canadian jurisdictions and other countries places further strains on the system.

During 2001-2002, a comprehensive review of the health and social services system was commissioned by the NWT Department of Health and Social Services. This review was designed to further define structural and operational system issues that were described in the *Ministers' Forum on Health and Social Services*. The review included extensive consultations with individuals who play a leadership role in the NWT health system, as well as individual employees.

The recommendations of the system review were then used to shape the *NWT Health and Social Services System Action Plan*, released in January 2002. The Plan contained 45 actions identified under five broad areas of improvement: services to people, support to staff, support to trustees, system-wide management and system-wide accountability. The implementation of the Action Plan is to begin early in 2002-2003 and is expected to continue over the next two years.

One of the most significant areas for improvement is to decrease the NWT reliance on other jurisdictions for key health and social care professionals. Improving in entry-level training programs targeted at northerners in general and at northern Aboriginal people as key providers of health and social care services is a high priority for the NWT.

Information Technology

Considering the relatively small population distributed over a large and isolated area, the NWT is using new information technologies as a means to improve communications between communities. However, these are the same factors that make it costly and difficult to provide and maintain technological solutions in the NWT.

Data quality and integrity continue to be a challenge in the NWT. It has become increasingly important that new integrated information systems created for the Department and the Authorities be developed with recognition of issues related to client privacy. Vendors are responding to these challenges by improving the access and security facilities in new applications and infrastructures. The NWT is moving forward to harness these new opportunities as quickly as its financial resources permit.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The name of the plan in the NWT is The Northwest Territories Health Care Plan, which includes the Medical Care Plan and the Hospital Insurance Plan. The public authority responsible for the administration of the Medical Care Plan is the Director of Medical Insurance as appointed under the *Medical Care Act*. The Minister administers the Hospital Insurance Plan either through boards of management established under section 10 of the *Hospital Insurance and Health and Social Services Administration Act (HIHSSA)* or pursuant to section18 of the same Act, which allows the Minister to approve a contract for the management of health and social services facilities.

Legislation that enables the Plan in the Northwest Territories includes the *Medical Care Act* (revised 1988) and the *Hospital Insurance and Health and Social Services Administration Act* (revised 1997). In January 2001, sections of the *Medical Care Act* Regulations pertaining to fee schedules were amended to reflect the negotiated contract between the NWT Medical Association and the Department of Health and Social Services. Contract negotiations, which began in October 2002, may result in amendments to the fee schedule in 2003.

The powers of the Minister are outlined in section15 of the *Health Insurance and Health and Social Services Administration Act* and the Minister's mandate is further described in the Establishment Policy for the Department of Health and Social Services.

1.2 Reporting Relationship

In the Northwest Territories, the Minister of Health and Social Services appoints a Director of Medical Insurance. The Director is responsible for the administration of the *Medical Care Act* and the Regulations. The Director must report to the Minister each fiscal year respecting the operation of the Medical Care Plan.

The Minister also appoints members to the Board of Management for facilities located throughout the Northwest Territories. Boards of Management are established under section 10 of the *Hospital Insurance and Health and Social Services Administration Act* or under the *Societies Act*. The Boards are established with the authority to manage, control and operate health and service facilities and, subject to the *Financial Administration Act* (1987), exercise any powers necessary and incidental to these duties. The Boards' chairpersons hold office during the pleasure of the Minister, while the remaining members typically hold office for a term of three years, to a maximum of three consecutive terms.

Pursuant to the *Financial Administration Act*, an annual audit of accounts is done at each Board of Management. The Minister has regular meetings with chairpersons of the Boards of Management. This forum allows the chairperson to provide non-financial reporting.

1.3 Audit of Accounts

The Hospital Insurance Plan and the Medical Care Plan are administered by the Department of Heath and Social Services. The Auditor General of Canada (AGC) has the mandate to audit the payments made under the Medical Care Plan. As part of the Public Accounts Audit, the AGC also audits the Hospital Insurance Plan.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Insured Hospital Services are provided under the authority of the *Hospital Insurance and Health and Social Services Administration Act* and the Regulations. During 2001-2002 four hospitals and 28 health centres delivered insured hospital services to both in- and out-patients.

The Northwest Territories provides a full range of insured hospital services. Boards of Management have the authority to provide services above those considered medically necessary, although those services are not covered by the insurance plans. NWT insured in-patient services include:

- accommodation and meals at the standard ward level;
- necessary nursing services;
- laboratory, radiological and other diagnostic procedures, together with the necessary interpretations;
- drugs, biological and related preparations prescribed by a physician and administered in hospital;
- routine surgical supplies;
- use of operating room, case room and anaesthetic facilities;
- use of radiotherapy and physiotherapy services, where available;
- psychiatric and psychological services provided under an approved program; services rendered by persons who are paid by the hospital; and
- services rendered by an approved detoxification centre.

The NWT also provide a number of out-patient services. These include:

- laboratory tests, x-rays including interpretations, when requested by a physician and performed in an out-patient facility or in an approved hospital;
- hospital services in connection with most minor medical and surgical procedures;
- physiotherapy, occupational therapy and speech therapy services in an approved hospital; and
- psychiatric and psychology services provided under an approved hospital program.

A detailed list of insured in- and out-patient services is contained in the Hospital Insurance Regulations. Section 1 of the Hospital Insurance Regulations states that "out-patient insured services" means the following services and supplies given to out-patients:

> (a) laboratory, radiological and other diagnostic procedures together with the necessary interpretations for the purpose of assisting in the diagnosis and treatment of any injury, illness or disability, but not including simple procedures such as examinations of blood and urine which ordinarily form part of a physician's routine office examination of a patient,
>
> (b) necessary nursing service,
>
> (c) drugs, biologicals and related preparations as provided in Schedule B,
> when administered in the hospital,
>
> (d) use of operating room and anaesthetic facilities including necessary equipment and supplies,
>
> (e) routine surgical supplies,
>
> (f) services rendered by persons who receive remuneration for those services from the hospital,
>
> (g) use of radiotherapy facilities,
>
> (h) use of physiotherapy facilities.

The Minister may add insured hospital services to the Regulations. As such, on the Minister's recommendation, the Commissioner may make Regulations prescribing the in- and out-patient services that insured persons are eligible for and entitled to. The Minister also determines if any public consultation will occur prior to making changes to the list of insured services.

Where insured services are not available in the Northwest Territories, NWT residents can receive them from hospitals in other jurisdictions. These services must be medically necessary and can include hospital-to-hospital transfer as well as referral from physicians. The NWT provides medical travel assistance, a supplementary health benefit program outlined in the Medical Travel Policy, which ensures that NWT residents can have access to medically required services.

2.2 Insured Physician Services

The NWT *Medical Care Act* and the NWT Medical Care Regulations provide for insured physician services. Only medical doctors, as medical practitioners, are allowed to deliver insured physician services in the NWT. The physician must be licensed to practice in the NWT.

A wide range of medically necessary services are provided in the NWT. No limitation will be applied if a service has been deemed an insured service. The Medical Care Plan insures all medically required procedures provided by medical practitioners, including approved diagnostic and therapeutic services; necessary surgical services; complete obstetrical care; eye examinations; and visits to specialists, even when there is no referral by a family physician.

Following negotiations between the NWT Medical Association and the Director of Medical Insurance, additional medical services may be considered for inclusion to the fee schedule Regulation. It is the responsibility of the Director of Medical Insurance to manage the process of adding or deleting a medical service and to determine if public consultations are appropriate before changes are made to the approved schedules. However, it is the Minister who makes the determination to add or delete insured hospital services to the Regulations. On the recommendation of the Minister, the Commissioner may approve Regulations as follows:

- "establishing a Medical Care Plan for providing to insured persons insured services by medical practitioners that will in all respects qualify and enable the Territories to receive payments of contributions from the Government of Canada under the *Canada Health Act*".
- "prescribing rates of fees and charges that may be paid in respect of insured services rendered by medical practitioners whether in or outside the Territories, and the conditions under which the fees and charges are payable."

2.3 Insured Surgical-Dental Services

Insured services and those related to oral surgery, injury to the jaw, or disease of the mouth/jaw are eligible. Only oral surgeons may submit claims for billing. During the reporting period, there was no oral surgeon in the NWT. As a result the NWT uses the Province of Alberta Schedule of Oral and Maxillofacial Surgery Benefits as a guide.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Services provided by hospitals, physicians, and dentists, but not covered by the health care insurance plan of the NWT include:

- medical-legal services;
- third-party examinations;
- services not medically required;
- group immunization;
- *in-vitro* fertilization;
- services provided by a doctor to his or her own family;
- advice or prescriptions given over the telephone;
- surgery for cosmetic purposes except where medically required;
- dental services other than those specifically defined for oral surgery;
- dressings, drugs, vaccines, biologicals and related materials;
- eyeglasses and special appliances;
- plaster, and surgical appliances or special bandages;
- treatments in the course of chiropractics, podiatry, naturopathy, osteopathy or any other practice ordinarily carried out by persons who are not medical practitioners as defined by the *Medical Care Act and Regulations*;
- physiotherapy and psychology services received from other than an insured out-patient facility;
- services covered by the *Workers' Compensation Act* or by other federal or territorial legislation; and

☐ routine annual checkups where there is no definable diagnosis.

In the NWT, prior approvals of uninsured medical goods or services provided in conjunction with an insured health service must adhere to the procedure in place. The procedure includes seeking advice from the Medical Advisor. The Medical Advisor is appointed to provide medical expertise to the Director of Medical Insurance. This approach does not compromise reasonable access to insured services for NWT residents.

The NWT *Medical Care Act* includes medicare Regulations as well as a Physician Fee schedule. This Act also provides for the authority to negotiate changes or deletions to the Physician Fee Schedule. The process was described in section 2.2 of this report.

3.0 Universality

3.1 Eligibility

The *Medical Care Act* is the legislation that defines the eligibility of Northwest Territories residents to the NWT health care insurance plan.

The Northwest Territories uses the Interprovincial Agreement on Eligibility and Portability in conjunction with the Northwest Territories Health Care Plan Registration Guidelines to define eligibility. No changes to eligibility have been implemented in 2001-2002.

Ineligible individuals for Northwest Territories health care coverage are members of the Canadian Forces, the Royal Canadian Mounted Police, federal inmates, and residents who have not completed the minimum waiting period.

3.2 Registration Requirements

Registration requirements include a completed application form and supporting documentation as applicable, e.g. visas and immigration papers. The individual must be prepared to provide proof of residency if requested. Registration should optimally occur prior to the actual eligibility date of the client. Renewal of health care cards is done every two years. There is a direct link between registration and eligibility for coverage. Claims are not paid for clients who do not have valid registration.

As of March 31, 2002, there were 42,886 individuals registered with the Northwest Territories Health Care Plan. The registered number is from the NWT Department of Health and Social Services health care plan registration database. At any point in time, it is possible for more people to be registered than actually live in the NWT. For example, people do not always immediately inform the Department when they have moved out of the NWT.

No formal provisions are in place for clients to opt out of the health care insurance plan.

3.3 Other Categories of Individual

Holders of employment visas, student visas, and in some cases visitor visas are covered if they hold valid visas for a period of 12 months or more.

4.0 Portability

4.1 Minimum Waiting Period

There are waiting periods imposed on insured persons moving to the Northwest Territories. The waiting periods are consistent with the Interprovincial Agreement on Eligibility and Portability. Generally the waiting periods are the first day of the third month of residency, for those who move permanently to the NWT, or the first day of the thirteenth month for those with temporary employment of less than 12 months but who can confirm that the employment period has been extended beyond the 12 months.

4.2 Coverage During Temporary Absences In Canada

The Interprovincial Agreement on Eligibility and Portability and the Northwest Territories Health Care Plan Registration Guidelines define the portability of health insurance during temporary absences within Canada.

Coverage is provided to students who are temporarily out of the Northwest Territories for full-time attendance in a post-secondary institution, and for up to one year for individuals who are temporarily absent from the Northwest Territories for work, vacation, secondments etc. When an individual is approved as being temporarily absent from the Northwest Territories, the full cost of insured services is paid for all services received in other jurisdictions.

The Northwest Territories participates in both the Hospital Reciprocal Billing Agreements and the Medical Reciprocal Billing Agreements with other jurisdictions.

4.3 Coverage During Temporary Absences Outside Canada

The Northwest Territories Health Care Plan Registration Guidelines set the criteria to define coverage for absences outside Canada. Individuals are granted coverage for up to one year if they are outside the country for any reason.

As per section 11. (b) (ii) of the *Canada Health Act*, insured residents may submit receipts for costs incurred for services received outside Canada. The NWT does provide personal reimbursement when an NWT resident leaves Canada for a temporary period for personal reasons such as vacations and requires medical attention during that time. Individuals will be required to cover their own costs and seek reimbursement upon their return to the NWT. The rates are the same as those contained in the Fee Schedule for physicians and the hospital out- or in-patient rate.

During the reporting period, no-one was granted authorization to continue with their NWT Health care coverage while remaining outside of Canada for up to one year. In the eligibility rules, NWT residents may continue their coverage up to one year if they are leaving Canada, but they must provide extensive information confirming that they are maintaining their permanent residence in the NWT. As there was no-one covered by this clause no payments were required. The rates are the same as those contained in the Fee Schedule for physicians and the hospital out- or in-patient rate.

4.4 Prior Approval Requirement

The NWT requires prior approval if coverage is to be considered for elective services in other provinces, territories and outside the country. Prior approval is also required if insured services are to be obtained from private facilities.

5.0 Accessibility

5.1 Access to Insured Health Services

The Medical Travel Supplementary Health Benefit Program ensures that economic barriers are reduced for all Northwest Territories residents. As per section 14 of the *Medical Care Act*, extra-billing is not allowed.

5.2 Access to Insured Hospital Services

There were no problems with accessibility of beds in the NWT during the reporting period. If this situation were to arise, the resident would be transported to another facility where appropriate beds exist. NWT hospitals and health centres continued to face some short-term staffing difficulties that had negative impacts on the operations. However, through the use of medical travel arrangements, access to services was maintained throughout 2001-2002.

The Northwest Territories' facilities do offer a range of medical, surgical, rehabilitative and diagnostic services. The NWT medical travel program ensures that residents may have access necessary services not available in NWT facilities,.

In order to improve access to insured hospital services, the NWT continued its expansion of the telehealth program in 2001-2002. A number of steps were taken to ensure that installation of equipment and the upgrading of the three existing WestNet sites (Inuvik, Fort Smith and Yellowknife) were completed in 2001-2002. In addition, new equipment was installed in four communities (Deline, Fort Simpson, Hay River and Holman).

5.3 Access to Insured Physician and Dental-Surgical Services

All residents of the Northwest Territories have access to all facilities operated by the Government of the Northwest Territories.

The medical travel program provides access to physicians for residents and the telehealth program has provided an expansion of specialist services to residents in isolated communities.

5.4 Physician Compensation

The *Medical Care Act* and the Medical Care Regulations are used in the Northwest Territories to govern payments to physicians. To compensate physicians, the NWT uses two models: fee-for-service and employee contracts. While the majority of family physicians opted out of fee-for-service and agreed to a contractual arrangement with the Northwest Territories, 10 percent of general practitioners have remained on fee-for-service.

Fee-for-service physician compensation is determined by negotiations between the Northwest Territories Medical Association and the Department of Health and Social Services. The Director of Medical Insurance and his or her designates negotiate on behalf of the Department. The Northwest Territories Medical Association chooses a negotiation team from within their membership. The NWT Fee Schedule and specialists contract for Specialists at Stanton Territorial Heath Authority expired on March 31, 2002. The general practitioners standardized employment contract remains in effect until March 31, 2003.

5.5 Payments to Hospitals

Payments made to hospitals are based on contribution agreements between the Boards of Management and the Department of Health and Social Services. Amounts allocated in the agreements are based upon the resources available in the total government budget and level of services provided by the hospital.

Payments to facilities providing insured hospital services are governed under the *Hospital Insurance and Health and Social Services Administration Act* and the *Financial Administration Act*. No amendments were implemented in 2001-2002. A global budget is used to fund hospitals in the Northwest Territories.

6.0 Recognition Given to Federal Transfers

Federal funding received through the Canada Health and Social Transfer has been recognized and reported by the Government of the Northwest Territories through press releases and various other documents. For fiscal year 2001-2002, these documents included:

- ☐ 2001-2002 Budget Address
- ☐ 2001-2002 Main Estimates
- ☐ 2000-2001 Public Accounts and,
- ☐ 2001-2004 Business Plans for the Department of Finance and the Department of Health and Social Services.

The Estimates noted above represent the financial plan of the GNWT and is presented each year by the Government to the Legislative Assembly.

7.0 Extended Health Care Services

7.1 Nursing Home Intermediate Care and Adult Residential Care Services

Supported living services provide a home-like environment with increased assistance and a degree of supervision unavailable through home care services. Current services in this area include supported living arrangements in apartments and group homes, where clients are grouped according to needs and live as independently as possible. Group homes, long term care facilities and extended care facilities provide more complex medical, physical and/or mental supports on a 24 hour basis.

Programs and services offered in NWT communities may include: Supported Living; Adult Group Homes; Long-Term Care Facilities and Extended Care Facilities. These programs and services operate where applicable according to the Department of Health and Social Services Establishment Policy, the Hospital Insurance and Health and *Social Services Administration Act* and the Hospital Standards Regulations.

The NWT Home Care Program is a territorial-wide program established to provide effective, reliable and responsive community health care services to support independent living; to develop appropriate care options to support continued community living; and to facilitate admission to institutional care when community living is no longer a viable alternative. Home care services are delivered through the Regional Health and Social Services Authorities and include a broad range of services based on a multidisciplinary assessment of individual needs. The Home Care Program currently services the six regions of Yellowknife, Hay River, Fort Smith, Inuvik, Deh Cho, and Dogrib.

8.0 Provision of Additional Materials

The NWT health and social services system has been extensively reviewed over the past few years. This includes the Legislative Assembly's Special Committee on Health and Social Services (1993), the Med-Emerg Review (1997) and the Minister's Forum on Health and Social Services (2000). During the reporting period, the Minister of Health and Social Services took into account the many recommendations brought forward and in January 2002, the Minister released the NWT Health and Social Services System Action Plan. Copies of the Action Plan and other materials produced by the NWT Department of Health and Social Services can be found at

www.hlthss.gov.nt.ca

In addition, NWT legislation, Regulations and other documents such as the Main Estimates can be found at

www.gov.nt.ca

Nunavut

Introduction

Nunavut was formed as a Territory on April 1,1999. The Territory covers one fifth of Canada's total landmass. There are twenty-six communities situated across three time zones. The Territory is divided into three regions: the Baffin, which consists of 13 communities; the Kivalliq, which consists of eight communities; and the Kitikmeot, which consists of five communities. According to recent statistics, the population of Nunavut is 26,745. This represents an 8.1 percent increase since the 1996 census. Inuit make up the majority at about 85 percent of the residents. There is a small French-speaking population of about four to six percent residing on Baffin Island, predominantly in the capital city of Iqaluit. Nunavut has a highly transient workforce, particularly skilled labourers and other seasonal workers from other provinces and territories.

Legislation governing the administration of health and social services in Nunavut was carried over from the Northwest Territories as Nunavut statutes pursuant to *Nunavut Act* (1999). Over the coming years, the Department of Health and Social Services plans to review all existing legislation to ensure its relevancy and appropriateness for the Government of Nunavut as set out in the objectives of the Bathurst Mandate. The Bathurst Mandate outlines the Government's agenda to achieve healthy communities, simplicity and unity, self-reliance, and continuous learning. The incorporation of traditional Inuit values, known as Inuit Qaujimajatuqangit, in program policy development, service design and delivery, is an expectation placed on all departments.

The delivery of health services in Nunavut is based on a primary health care model. There is a local health centre in each of the 25 communities across Nunavut, as well as one regional hospital in Iqaluit. The primary health care providers are nurse practitioners, with the exception of seven physicians located at the hospital in Iqaluit, one physician located at the health centre in Pond Inlet, and one physician in private practice in Iqaluit. Nunavut relies heavily on the Northern Medical Unit of the University of Manitoba, Ottawa Health Services Network Inc., and Stanton Regional Hospital in Yellowknife for the majority of its physician and specialist services.

The management and delivery of health services in Nunavut was integrated into the overall operations of the Department on March 31, 2000 when the former boards (Baffin, Kitikmeot and Kivalliq) were dissolved. Former board staff became employees of the Department at that time. The Department has a regional office in each of the three regions, which manages the delivery of health services at a regional level. A continued emphasis on support to front-line service delivery has remained an integral part of this amalgamation.

The Territorial budget for health care and social services in 2001-2002 was $153 million, with approximately $4.3 million allocated for capital. Only the Department of Education has a higher budget.

In 2000-2001, telehealth services were developed in five communities in Nunavut. In March 2001 the Department was advised that its proposal under the Canada Health Info-structure Partnerships Program was approved to enable expansion of telehealth services to an additional 10 communities over the next two years. The 10 new sites were selected in 2001-2002 and the telehealth project is progressing well.

Nunavut has many unique needs and challenges with respect to the health and well being of its residents. Approximately one fifth of the Department's budget is spent on medical travel. Due to the very low population density in this vast territory and limited health infrastructure (equipment and health human resources), access to a range of hospital and specialist services often requires that residents be sent out of the Territory. A new regional hospital in Iqaluit and new regional health facilities in Rankin Inlet and Cambridge Bay that will be built over the next three years will enable Nunavut to build internal capacity and enhance the range of services that can be provided within the Territory.

There continue to be high rates of respiratory diseases such as tuberculosis. Nunavut continues to be challenged by the acute shortage of nurses, despite aggressive national and international recruitment and retention activities. Recruitment and retention of other health care professionals such as social workers, physicians and physiotherapists is also a challenge.

Health promotion and prevention activities are high on the Department's list of service priorities. This includes strategies to reduce tobacco use, public education for healthy lifestyle choices, importance of traditional foods, etc.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The health care insurance plans of Nunavut, including physician and hospital services, are administered by the Department of Health and Social Services on a non-profit basis.

The *Medical Care Act* (NWT, 1988 and as duplicated for Nunavut by section 29 of the *Nunavut Act*, 1999) governs the entitlement to and payment of benefits for insured medical services. The *Hospital Insurance and Health and Social Services Administration Act* (NWT, 1988 and as duplicated for Nunavut by section 29 of the *Nunavut Act*, 1999) enables the establishment of hospital and other health services.

Through the *Dissolution Act* (Nunavut, 1999) the three former Health and Social Services Boards of Baffin, Kitikmeot and Kivalliq were dissolved and their operations were integrated into the Department of Health and Social Services effective April 1, 2000. Regional sites were maintained to support front-line workers and community-based delivery of a wide range of health and social services.

There have been no legislative amendments for the fiscal year 2001-2002.

1.2 Reporting Relationship

A Director of Medical Care is appointed under the *Medical Care Act* and is responsible for the administration of the Territory's medical care insurance plan. The Director reports to the Minister of Health and Social Services and is required to submit an annual report on the operations of the medical insurance plan. The Department tabled its first report for 1999-2000 and 2000-2001 in the Legislative Assembly in February 2002. Our annual submissions to the Canada Health Act Annual Report serve as the basis for these reports under the *Medical Care Act*.

1.3 Audit of Accounts

The Auditor General of Canada is the auditor of the Government of Nunavut in accordance with section 30.1 of the *Financial Administration Act* (Nunavut, 1999). The Auditor General has the mandate to audit the activities of the Department of Health and Social Services.

The Auditor General is required to conduct an annual audit of the transactions and consolidated financial statements of the Government.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Insured Hospital Services are provided in Nunavut under the authority of the *Hospital and Social Services Administration Act and Regulations* sections 2 to 4. No amendments were made to legislation or Regulations in 2001-2002.

In 2001-2002, insured hospital services were delivered in 26 facilities throughout Nunavut, including a general hospital located in Iqaluit and 25 community health centres. The Baffin Regional Hospital in Iqaluit is the only acute care facility in Nunavut providing a range of in- and out-patient hospital services as defined by the *Canada Health Act*. Community health centres provide public health, out-patient services, emergency room services and some overnight services (observations). There are also a limited number of birthing beds at the Rankin Inlet Birthing Centre. Public health services are provided at a Public Health Clinic in Rankin Inlet and Iqaluit.

The Department is responsible for authorizing, licensing, inspecting and supervising all health facilities and social services facilities in the Territory.

Insured in-patient hospital services include:

- accommodation and meals at the standard ward level;
- necessary nursing services;
- laboratory, radiological and other diagnostic procedures, together with the necessary interpretations;
- drugs, biological and related preparations prescribed by a physician and administered in hospital;
- routine surgical supplies;
- use of operating room, case-room and anaesthetic facilities;
- use of radiotherapy and physiotherapy services, where available;
- psychiatric and psychological services provided under an approved program;
- services rendered by persons who are paid by the hospital; and
- services rendered by an approved detoxification centre.

Out-patient services include:

- laboratory tests and x-rays, including interpretations, when requested by a physician and performed in an out-patient facility or in an approved hospital;
- hospital services in connection with most minor medical and surgical procedures;
- physiotherapy, occupational therapy, audiology and speech therapy services in an out-patient facility or in an approved hospital; and
- psychiatric and psychology services provided under an approved hospital program.

The Department of Health and Social Services makes the determination to add insured services in its facilities based on the availability of appropriate resources, equipment and overall feasibility in accordance with financial guidelines set by the Department and with the approval of the Nunavut Financial Management Board. No new services were added in 2001-2002 to the list of insured hospital services.

2.2 Insured Physician Services

The *Medical Care Act*, section 3(1) and Medical Care Regulations, section 3, provide for insured physician services in Nunavut. No amendments were made to legislation or Regulations in 2001-2002.

Medical doctors are the only medical practitioners permitted to deliver insured physician services in Nunavut. The physician must be in good standing with a College of Physicians and Surgeons and be licensed to practise in Nunavut. The Government of Nunavut's Medical Registration Committee currently manages this process for Nunavut physicians. There are a total of nine physicians in Nunavut (one in private practice, seven at the Baffin Regional Hospital in Iqaluit and one at the health centre in Pond Inlet), as well as one surgeon at the Baffin Regional Hospital, providing services to Nunavummiut. Visiting specialists, general practitioners and locums, through arrangements made by each of the Department's three regions, also provide insured physician services. There were a total of 148 physicians participating in the health insurance plan as of March 31, 2002.

Physicians can make an election to collect fees other than those under the Medical Care Plan in accordance with section 12 (2)(a) or (b) of the *Medical Care Act* by notifying the Director in writing. An election can be revoked the first day of the following month after a letter to that effect is delivered to the Director. In 2001-2002, no physicians provided written notice of this election.

Insured physician services means all services rendered by medical practitioners that are medically required. Where the insured service is unavailable in Nunavut, the patient is referred to another jurisdiction to obtain the insured service.

The addition or deletion of insured physician services requires government approval. For this, the Director of Medical Insurance would become involved in negotiations with a collective group of physicians to discuss the service, then the decision of the group would be presented to Cabinet for approval. No additions or deletions were added in 2001-2002.

2.3 Insured Surgical-Dental Services

Dentists providing insured surgical-dental services under the Medical Care Insurance Plan of the Territory must be licensed pursuant to the *Dental Professions Act* (NWT, 1988 and as duplicated for Nunavut by section 29 of the *Nunavut Act*, 1999) and are provided billing numbers for the purpose of billing the Plan for the provision of insured dental services. In 2001-2002, three oral surgeons were permitted to bill the Nunavut Medical Care Insurance Plan for insured dental services.

Insured dental services are limited to those dental-surgical procedures scheduled in the Regulations, requiring the unique capabilities of a hospital for their performance, for example, orthognathic surgery.

The addition of new surgical-dental services to the list of insured services requires government approval; no new services were added to the list in 2001-2002.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Services provided for under the *Workers' Compensation Act* (NWT, 1988 and as duplicated for Nunavut by section 29 of the *Nunavut Act*, 1999) or other Acts of Canada, except the *Canada Health Act*, are excluded.

Services provided by physicians that are not insured include:

- yearly physicals;
- cosmetic surgery;
- services that are considered experimental;
- prescription drugs;
- physical examinations done at the request of a third party;
- optometric services;
- dental services other than specific procedures related to jaw injury or disease;
- the services of chiropractors, naturopaths, podiatrists, osteopaths, and acupuncture treatments; and
- physiotherapy, speech therapy and psychology services, received in a facility that is not an insured out-patient facility (hospital).

Services not covered in a hospital include:

- hospital charges above the standard ward rate for private or semi-private accommodation;
- services that are not medically required, such as cosmetic surgery;
- services that are considered experimental;
- ambulance charges (except inter-hospital transfers);
- dental services, other than specific procedures related to jaw injury or disease;
- alcohol and drug rehabilitation, unless prior approved.

The Baffin Regional Hospital charges $2,180.25 per diem for services provided for non-Canadian resident stays.

When residents are sent out of the Territory for services, the Department relies on the policies and procedures guiding that particular jurisdiction when they provide services to Nunavut residents that could result in additional costs, only to the extent that these costs are covered by Nunavut's Medical Insurance Plan (see 4.2 under Portability). Any query or complaint is handled on an individual basis with the jurisdiction involved.

The Department also administers the Non-Insured Health Benefits (NIHB) Program on behalf of Health Canada for Inuit and First Nations residents in Nunavut. NIHB covers a co-payment for medical travel, accommodations and meals at boarding homes (in Ottawa, Winnipeg, Churchill, Edmonton and Yellowknife), prescription drugs, dental treatment, vision care, medical supplies and prostheses, and a number of other incidental services for Inuit and First Nations.

3.0 Universality

3.1 Eligibility

Eligibility for the Nunavut Health Care Plan is briefly defined under section 3(1)(2)(3) of the *Medical Care Act*. The Department also adheres to the Inter-Provincial/Territorial Agreement on Eligibility and Portability as well as internal guidelines. No amendments were made to the legislation or Regulations in 2001-2002.

Subject to these provisions, every Nunavut resident is eligible for and entitled to insured health services on uniform terms and conditions. A resident means a person lawfully entitled to be or to remain in Canada, who makes his or her home and is ordinarily present in the Territory, but does not include a tourist, transient or visitor to the Territory. Applications are accepted for health coverage and supporting documentation is required to confirm residency. Eligible residents receive a health card with a unique health care number.

Coverage generally begins the first day of the third month after arrival in the Territory but first-day coverage is provided under a number of circumstances, e.g., newborns whose mothers or fathers are eligible for coverage. As well, permanent residents (landed immigrants), returning Canadians, repatriated Canadians, returning permanent residents, and a non-Canadian who has been issued an employment visa for a period of 12 months or more are also granted first-day coverage.

Members of the Canadian Armed Forces, the Royal Canadian Mounted Police and inmates of a federal penitentiary are not eligible for registration. These groups are granted first-day coverage under the Nunavut Health Care Plan upon discharge.

Pursuant to section 7 of the Inter-Provincial/Territorial Agreement on Eligibility and Portability, persons in Nunavut who are temporarily absent from their home province/territory and who are not establishing residency in Nunavut remain covered by their home provincial or territorial health insurance plans for up to one year.

3.2 Registration Requirements

Registration requirements include a completed application form and supporting documentation. A health care card is issued to each resident. Nunavut will be going to a staggered renewal process once a new health claims system is put into place next fiscal year. No premiums exist. Coverage under the Nunavut Medical Insurance Plan is linked to verification of registration, although every effort is made to ensure registration occurs when a coverage issue arises for an eligible resident. For non-residents, a valid health care card from their home province/territory is required.

As of March 31, 2002, there were approximately 28,630 residents registered with the Nunavut Health Care Plan. Nunavut's population statistics as published by Statistics Canada includes a number of "temporary residents" who are not eligible for coverage under the Territory's health plan. There are no formal provisions for Nunavut residents to opt out of the health care insurance plan.

3.3 Other Categories of Individual

Non-Canadian holders of employment visas of less than 12 months, foreign students with visas of less than 12 months, transient workers and individuals holding a Minister's Permit (with one exception) are not eligible for coverage. When unique circumstances occur, assessment is done on an individual basis. This is consistent with section 15 of the NWT's Guidelines for Health Care Plan Registration, which were adopted by Nunavut in 1999.

4.0 Portability

4.1 Minimum Waiting Period

Consistent with section 3 of the Inter-Provincial/Territorial Agreement on Eligibility and Portability, the waiting period before coverage begins for individuals moving within Canada is three months or the first day of the third month following the establishment of residency in a new province or territory or the first day of the third month when an individual who has been temporarily absent from his or her home province decides to take up permanent residency in Nunavut.

4.2 Coverage During Temporary Absences In Canada

The *Medical Care Act*, section 4(2), prescribes the benefits payable where insured medical services are provided outside Nunavut but within Canada. The *Hospital Insurance and Health and Social Services Administration Act*, sections 5(d) and 28(1)(j)(o) provide the authority for the Minister to enter into agreements with other jurisdictions to provide health services to Nunavut residents and the terms and conditions of payment. No legislative or regulatory changes were made in 2001-2002 with respect to coverage outside Nunavut.

Students studying outside Nunavut must notify the Department and provide proof of enrolment to ensure coverage continues. Requests for extensions must be renewed yearly and are subject to approval by the Director. Temporary absences for work, vacation or other reasons for up to one year are approved by the Director upon receipt of a written request from the insured person. The Director may approve absences in excess of 12 continuous months upon receipt of a written request from the insured person.

The provisions regarding coverage during temporary absences in Canada fully comply with the terms and conditions of the Inter-Provincial/Territorial Agreement on Eligibility and Portability, as of January 1, 1998.

Nunavut participates in Physician and Hospital Reciprocal Billing; and agreements are in place with other provinces and territories (Ontario, Manitoba, Alberta and the Northwest Territories).

The Hospital Reciprocal Billing Agreements provide payment of in- and out-patient hospital services to eligible Nunavut residents receiving insured services outside the Territory. High-cost procedure rates, newborn rates and out-patient rates are based on those established by the Coordinating Committee on Reciprocal Billing. A special agreement exists between the Northwest Territories and Nunavut Territory which, based on a block-funding approach, enables the Stanton Hospital in Yellowknife to provide services to Nunavut residents in the hospital and through visiting specialist services in the Kitikmeot area (Western Arctic).

The Physician Reciprocal Billing Agreements provide payment of insured physician services on behalf of eligible Nunavut residents receiving insured services outside the territory. Payment is made to the host province at the rates established by that province.

Out-of-territory hospitals were paid $9,206,864 in the fiscal year 2001-2002.

4.3 Coverage During Temporary Absences Outside Canada

The *Medical Care Act*, section 4(3) prescribes the benefits payable where insured medical services are provided outside Canada. The *Hospital Insurance and Health and Social Services Administration Act*, section 28(1)(j)(o) provides the authority for the Minister to set the terms and conditions of payment for services provided to Nunavut residents outside Canada. Individuals are granted coverage for up to one year if they are temporarily out of the country for any reason although they must give prior notice in writing. For services provided to residents who have been referred out of the country for highly specialized procedures unavailable in Nunavut and Canada, Nunavut will pay the full cost. For non-referred or non-emergency services, the payment for hospital services is $1,396 per diem and $110 for out-patient care. No changes were made to these rates in 2001-2002.

Insured physician services provided to eligible residents temporarily outside the country are paid at rates equivalent to those paid had that service been provided in the Territory. Reimbursement is made to the insured person or directly to the provider of the insured service.

4.4 Prior Approval Requirement

Prior approval is required for elective services provided in private facilities in Canada or in any facility outside the country.

5.0 Accessibility

5.1 Access to Insured Health Services

The *Medical Care Act*, section 14, prohibits extra billing by physicians unless the medical practitioner has made an election that is still in effect. Access to insured services is provided on uniform terms and conditions. To break down the barrier posed by distance and cost of travel, the Government of Nunavut provides medical travel assistance. Interpretation services are also provided to patients in any health care setting.

5.2 Access to Insured Hospital Services

The Baffin Regional Hospital, located in Iqaluit, is the one acute care hospital facility in Nunavut. The hospital has 25 beds available for acute, rehabilitative, palliative and chronic care services. The hospital has a staff of 103, including 7 physicians and 33 nurses. The facility provides in-patient, out-patient, and 24 hour emergency services. Local physicians provide emergency services on rotation. Medical services provided include an ambulatory care/out-patient clinic, intensive care services, respiratory services, cardiovascular care, maternity, palliative care, gastrointestinal bleeds and hypertension treatment. Surgical services provided include minor orthopaedics, gynaecology, paediatrics, general abdominal, emergency trauma and ENT/otolaryngology. Patients requiring specialized surgeries are sent to other jurisdictions. Diagnostic services include radiology, laboratory and electrocardiogram. Rehabilitative services are limited to Iqaluit.

Nunavut has special arrangements with facilities in Ottawa, Toronto, Churchill (Manitoba), Winnipeg, Edmonton and Yellowknife to provide insured services to referred patients.

Outside the Baffin Regional Hospital, out-patient and 24 hour emergency services are provided by all 25 health centres located in the communities.

Although nursing and other health professionals were not at the desired levels of staffing, all basic services were provided in 2001-2002. Nunavut is seeking to increase resources in all areas.

5.3 Access to Insured Physician and Dental-Surgical Services

In addition to the medical travel assistance and telehealth initiatives, Nunavut has agreements with a number of health regions or facilities to provide medical and visiting specialists and other visiting health practitioner services. For services and equipment unavailable in Nunavut, patients are referred to other jurisdictions. In 2001-2002, there were 81 general family practitioners and 67 physician specialists providing services in Nunavut.

The following specialist services were provided under the visiting specialists program: ophthalmology, orthopaedics, internal medicine, otolaryngology, neurology, rheumatology, dermatology, paediatrics, obstetrics, physiotherapy, occupational therapy, psychiatry and dental surgery. Visiting specialist clinics are held depending on demand and availability of specialists.

5.4 Physician Compensation

There is one fee-for-service physician residing in Nunavut. Because fee-for-service physicians pay the expenses of running a practice in an isolated community, they are paid a rate 20 percent greater than the amounts set out in the schedule (per the *Medical Care Act* section 4). The fees are negotiated between the Department of Health and Social Services and the physician, and are based on the NWT standards. The remaining physicians are on contract at a per diem rate or are on salary. Visiting specialists are paid on a per diem basis under the terms of their contracts.

5.5 Payments to Hospitals

Funding for the Baffin Regional Hospital and the 25 community health centres are part of the Department's budget as represented in the budgets for regional operations. No payments are made directly to hospitals or community health centres.

6.0 Recognition Given to Federal Transfers

Recognition will be given this year when the Director of Medical Care presents the 2001-2002 annual report to the Minister. This report will be tabled in the Legislative Assembly in early 2003.

7.0 Extended Health Care Services

The Home Care Program assists Nunavut residents who are not fully able to care for themselves at home. A community-based visiting service encourages self-sufficiency and supports family members and community involvement to enable individuals to remain safely in their own homes. Services include basic housekeeping support, meal preparation and assistance with daily living.

Intermediate care is available at St. Theresa's Home in Chesterfield Inlet. The facility provides 24 hour care and is fully staffed with professional and para-professional personnel. Nursing services are available between 7 a.m. and 7 p.m. After-hours services are for personal care only. The community health centre provides after-hours medical attention.

Nursing home services are available at the Iqaluit and Arviat's Elders Homes. These facilities provide the highest level of long-term care in Nunavut, that is, extensive chronic care services up to the point of acute care (level 4 and 5) services. Acute care cases are transferred to the closest hospital.

The use of telehealth services has been a significant step in improving access to hospital, medical and other health and social services in Nunavut. Pilot projects are underway in five communities. To date, telehealth has been used for mental health counselling, family visits, and pre- and post-natal visits. The long-term goal is to integrate telehealth into the primary care delivery system and enable residents of Nunavut greater access to a broader range of service options for residents, providers and communities and to use existing resources more effectively. Our approved Canadian Health Infrastructure Partnerships Program proposal will allow Nunavut to expand telehealth services to an additional 10 communities.

Annex A - Provincial and Territorial Health Care Insurance Plan Statistics

Introduction

The purpose of this Annex is to place the administration and operation of the *Canada Health Act* in context and to provide a national perspective on trends in the delivery and funding of insured health services in Canada that are within the scope of the Act.

The Annex contains statistical data on the cost and utilization of insured hospital, physician and surgical-dental services for each province and territory for the five consecutive fiscal years ending on March 31 of 1997-1998, 1998-1999, 1999-2000, 2000-2001 and 2001-2002.

All information has been provided by provincial and territorial officials. In order to ensure consistency in reporting, Health Canada provided provincial/territorial governments with a user's guide outlining what and how to provide the information. The user's guide was prepared in consultation with representatives in each provincial and territorial government.

Although efforts were made to capture data on a consistent basis, differences exist in the reporting of health care programs and services between provincial and territorial governments. Therefore, comparisons between jurisdictions are not made.

Figures presented in the statistical annex are provided to Health Canada by provincial and territorial government authorities on a cooperative basis. Provincial and territorial governments are responsible for the quality and completeness of the data they provide. Again this year, the *Ministère de la Santé et des Services sociaux du Québec* chose not to present Health Canada with a submission for this statistical annex.

For a discussion of the associated programs on which the data in these tables are based, please refer to Chapter 3 – Provincial and Territorial Health Care Insurance Plans in 2001-2002.

Organization of the Information

Information in the tables on the following pages is organized into provincial and territorial sections of this annex and grouped according to the eight subcategories described below. In some cases data were not yet available and estimates were provided. In other cases, the requested statistics did not apply to the particular province or territory or were not available.

Registered Persons

Registered persons are the number of residents registered with the health care insurance plans of each province or territory. These estimates can be assessed with respect to the universality criterion of the *Canada Health Act* to assist Canadians, governments and stakeholders in reviewing the extent to which residents of provinces and territories have registered for coverage or chosen to opt out of their jurisdiction's health care insurance plan.

Insured Hospital Services within Own Province or Territory

Statistics on the provision of insured hospital services within each jurisdiction to residents of the jurisdiction and to visitors from other provinces or territories are provided in fields 2 through 13.

Details include numbers of facilities by type of care provided; number of beds; number of separations (i.e. persons released or discharged from health facilities); average length of stay; total payments in the province/territory per category of care; average cost per visit by type of care; and the number of, and payments to, private for-profit health care facilities.

These statistics are collected and presented to provide insights and understanding on how each provincial and territorial health insurance plan meets the requirements of the accessibility criterion of the *Canada Health Act* as it applies to insured hospital services.

Insured Hospital Services Provided to Residents in Another Province or Territory

This subsection presents out-of-province or out-of-territory insured hospital services that are paid for by a person's home jurisdiction when they travel to other parts of Canada. The information reported includes the total number of claims paid for insured hospital services in other provinces or territories, total payments made, and the average payment level.

These statistics can assist the federal Minister of Health in assessing provincial and territorial compliance with the in-country portability provisions in section 11(b)(i) of the *Canada Health Act* as they apply to insured hospital services.

Insured Hospital Services Provided Outside Canada

Hospital services provided out-of-country represent a person's hospital costs incurred while travelling outside of Canada that are paid for by their home province or territory. Statistics reported in this subsection are of the same type as hospital services provided out-of-province or out-of-territory.

These statistics can assist Canadians and the federal Minister of Health assess provincial and territorial compliance with the out-of-country portability provisions in section 11(b)(ii) of the *Canada Health Act* as they relate to insured hospital services.

Insured Surgical-Dental Services within Own Province or Territory

The information in this subsection describes insured surgical-dental services provided in each province and territory. This includes the number of participating professionals (dentists, dental surgeons, and oral surgeons); the number of services provided; total payments made in the fiscal year; and the average payment per service.

These statistics relate principally to the assessment of a province's or territory's compliance with the accessibility criterion of the *Canada Health Act* as it applies to insured surgical-dental services.

Insured Physician Services within Own Province or Territory

Statistics in this subsection relate to the provision of insured physician services to residents in each province or territory as well as to visitors from other regions of Canada.

Details include the number of physicians participating in the provincial or territorial health insurance plan; the number of physicians opted-out or not participating in the plan; the number of insured services provided; the total payments made to physicians by category of physician and by category of service; and the average payment level per insured physician service.

These statistics relate principally to the assessment of a province's or territory's compliance with the accessibility criterion of the *Canada Health Act* as it applies to insured physician services.

Insured Physician Services provided to Residents in Another Province or Territory

This subsection reports on physician services that are paid by a jurisdiction to other provinces or territories for their visiting residents. Statistics include the number of services paid, total payments made, and the average payment level per service.

These statistics can assist the federal Minister of Health in assessing provincial and territorial compliance with the in-country portability provisions in section 11(b)(i) of the *Canada Health Act* as they apply to insured physician services.

Insured Physician Services Provided Outside Canada

Physician services provided out-of-country represent a person's medical costs incurred while travelling outside of Canada that are paid for by their home province or territory. Statistics reported in this subsection are the same as for physician services provided out-of-province or out-of-territory.

These statistics can assist Canadians and the federal Minister of Health assess provincial and territorial compliance with the out-of-country portability provisions in section 11(b)(ii) of the *Canada Health Act* as they relate to insured physician services.

Newfoundland and Labrador

Registered Persons						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
1. Total number of persons registered under the health care insurance plan as of March 31st	(#)	635,835 [1]	622,744	618,118 [2]	616,944 [3]	565,000 [4]

Insured Hospital Services Within Own Province or Territory						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care:	(#)					
a. acute care		33	33	33	32	32
b. chronic care		0	0	0	0	0
c. rehabilitative care		0	0	0	0	0
d. out-patient diagnostic care		0	0	0	0	0
e. surgical day care (out-patient)		0	0	0	0	0
f. other		0	0	0	0	0
g. total facilities		33	33	33	32	32
3. Number of staffed beds in all facilities providing insured hospital services, by type of bed:	(#)					
a. acute care		1,842	1,814	1,807	not available	not available
b. chronic care		0	0	0	0	0
c. rehabilitative care		38	62	57	not available	not available
d. out-patient diagnostic care		0	0	0	0	0
e. other		0	0	0	0	0
f. total staffed beds		1,880	1,876	1,864	not available	not available
4. Approved bed complement for all facilities providing insured hospital services, by type of bed:	(#)					
a. acute care		1,842	1,814	1,807	not available	not available
b. chronic care		0	0	0	0	0
c. rehabilitative care		38	62	57	not available	not available
d. out-patient diagnostic care		0	0	0	0	0
e. other		0	0	0	0	0
f. total approved bed complement		1,880	1,876	1,864	not available	not available

[1] Data are as of December 31, 1997.

[2] Data are as of March 1, 2000.

[3] Data are as of April 11, 2001.

[4] Data are as of April 30, 2002.

Insured Hospitals Services Within Own Province or Territory						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
5. Number of separations from all facilities providing insured hospital services, by type of care:	(#)					
a. acute care		67,385	68,729	66,828	not available	not available
b. chronic care		0	0	0	0	0
c. rehabilitative care		54	227	272	not available	not available
d. out-patient diagnostic care		0	0	0	0	0
e. surgical day care		0	0	0	0	0
f. alternative level of care		0	0	0	0	0
g. newborns		0	0	0	0	0
h. other		0	0	0	0	0
i. total separations		67,439	68,956	67,100	not available	not available
6. Average length of in-patient stay in all facilities providing insured hospital services, by type of care:	# of days					
a. acute care		7.90	7.50	7.40	not available	not available
b. chronic care		0.00	0.00	0.00	0.00	0.00
c. rehabilitative care		not available	not available	not available	not available	not available
d. newborns		0.00	0.00	0.00	0.00	0.00
e. other		0.00	0.00	0.00	0.00	0.00
7. Payments to facilities providing insured hospital services, by the facility's primary type of care:	($)					
a. acute care		441,408,824 [1]	457,085,762 [1]	509,018,766 [1]	537,428,824 [1]	619,884,087 [1]
b. chronic care		0	0	0	0	0
c. rehabilitative care		0	0	0	0	0
d. out-patient diagnostic care		0	0	0	0	0
e. surgical day care (out-patient)		0	0	0	0	0
f. other		0	0	0	0	0
g. total payments to facilities providing insured hospital services		441,408,824 [1]	457,085,762 [1]	509,018,766 [1]	537,428,824 [1]	619,884,087 [1]
8. Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care:	($)					
a. acute care		675.00 [2]	690.00 [2]	690.00 [2]	705.00 [2]	725.00 [2]
b. chronic care		0.00	0.00	0.00	0.00	0.00
c. rehabilitative care		0.00	0.00	0.00	0.00	0.00
d. other		0.00	0.00	0.00	0.00	0.00

[1] Operating costs only: does not include capital, deficit or non-government funding. Payments represent the final provincial plan funding provided to regional health care boards for the purposes of delivering insured acute care services.

[2] Insured Canadian resident rate.

Insured Hospital Services Within Own Province or Territory						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care	($)					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. out-patient diagnostic care		not available	not available	not available	not available	not available
e. surgical day care (out-patient)		not available	not available	not available	not available	not available
f. other		not available	not available	not available	not available	not available
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care	($)					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. other		not available	not available	not available	not available	not available
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care	(#)					
a. private surgical facilities		1	1	1	1	1
b. private diagnostic imaging facilities		0	0	0	0	0
c. Total private for-profit health care facilities		1	1	1	1	1
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care	(#)					
a. private surgical facilities		not available	not available	not available	not available	not available
b. private diagnostic imaging facilities		0	0	0	0	0
c. Total insured hospital services provided at private for-profit health care facilities		not available	not available	not available	not available	not available
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care	($)					
a. private surgical facilities		93 809	212 990	387 030	270 750	338 200
b. private diagnostic imaging facilities		0	0	0	0	0
c. Total payments to private for-profit health care facilities		93 809	212 990	387 030	270 750	338 200

Insured Hospital Services Provided to Residents in Another Province or Territory		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
14. Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (in Canada)	(#)	1 970	1 826	1 549	1 699	1 681
15. Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (in Canada)	(#)	26 293	28 739	25 546	24 929	26 155
16. Total payments for out-of-province/territory, in-patient, insured hospital services (in Canada)	($)	11 286 130	12 037 091	10 144 354	10 608 388	10 312 515
17. Total payments for out-of-province/territory, out-patient, insured hospital services (in Canada)	($)	2 656 772	3 316 482	3 138 582	3 047 375	3 213 979
18. Average payment for out-of-province/territory, in-patient insured hospital services (in Canada)	($)	5 729.00	6 592.00	6 549.00	6 244.00	6 135.00
19. Average payment for out-of-province/territory, out-patient insured hospital services (in Canada)	($)	101.00	115.00	123.00	122.00	123.00

Insured Hospital Services Provided Outside Canada		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
20. Total number of claims paid for out-of-country, in-patient, insured hospital services	(#)	39	62	73	111	62
21. Total number of claims paid for out-of-country, out-patient, insured hospital services	(#)	376	383	260	287	258
22. Total payments for out-of-country, in-patient, insured hospital services	($)	161 343	503 043	198 072	1 102 540	123 682
23. Total payments for out-of-country, out-patient, insured hospital services	($)	38 985	58 614	15 626	36 280	22 567
24. Average payment for out-of-country, in-patient insured hospital services	($)	4 137.00	8 097.00	2 713.00	9 933.00	1 995.00
25. Average payment for out-of-country, out-patient insured hospital services	($)	104.00	156.00	60.00	126.00	87.00

Insured Surgical-Dental Services Within Own Province or Territory		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
26. Number of dentists participating in the health insurance plan	(#)	25	30	35	35	28
27. Number of insured surgical-dental services provided by participating dentists	(#)	10,000	10,000	9,000	11,000	10,000
28. Total payments to dentists for insured surgical-dental services	($)	328,000	374,000	354,000	389,000	409,000
29. Average payment per service for insured surgical-dental services	($)	32.48	38.34	38.73	35.08	39.92

Insured Physician Services Within Own Province or Territory		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
30. Number of physicians participating in the health insurance plan, by type of physician [1]	(#)					
a. general practitioners		not available	not available	432 [2]	437 [2]	448 [2]
b. specialists		not available	not available	480 [2]	485 [2]	504 [2]
c. other		not available	not available	not applicable	not applicable	not applicable
d. total		not available	not available	912 [2]	922 [2]	952 [2]
31. Number of physicians opted-out of the health insurance plan, by type of physician	(#)					
a. general practitioners		0	0	0	0	0
b. specialists		0	0	0	0	0
c. other		0	0	0	0	0
d. total		0	0	0	0	0
32. Number of physicians not participating in the health insurance plan, by type of physician	(#)					
a. general practitioners		0	0	0	0	0
b. specialists		0	0	0	0	0
c. other		0	0	0	0	0
d. total		0	0	0	0	0

[1] Excludes inactive physicians.

[2] Number of physicians paid on salary or fee-for-service basis.

Insured Physician Services Within Own Province or Territory						
		1997-1998	**1998-1999**	**1999-2000**	**2000-2001**	**2001-2002**
33. Number of insured physician services provided, by type of physician (fee-for-service):	(#)					
a. general practitioners		2,623,000	2,471,000	2,489,000	2,340,000	2,263,000
b. specialists		2,407,000	2,440,000	2,443,000	2,318,000	2,218,000
c. other		not applicable	not applicable	not applicable	not applicable	not applicable
d. total		5,030,000	4,911,000	4,932,000	4,657,000	4,481,000
34. Number of insured physician services provided, by category of service:	(#)					
a. medical		3,195,000	3,107,000	3,104,000	2,878,000	2,728,000
b. surgical		487,000	487,000	468,000	433,000	398,000
c. diagnostic		1,348,000	1,317,000	1,361,000	1,346,000	1,345,000
d. other		not applicable	not applicable	not applicable	not applicable	not applicable
e. total		5,030,000	4,911,000	4,932,000	4,657,000	4,481,000
35. Total payments to (fee-for-service) physicians for insured physician services, by type of physician:	($)					
a. general practitioners		40,956,000	41,521,000	42,429,000	43,251,000	42,751,000
b. specialists		67,314,000	71,640,000	72,780,000	73,239,000	75,177,000
c. other		not applicable	not applicable	not applicable	not applicable	not applicable
d. total		108,270,000	113,161,000	115,209,000	116,490,000	117,928,000
36. Total payments to physicians for insured physician services, by category of service:	($)					
a. medical		not available	not available	72,500	71,987	not available
b. surgical		not available	not available	10,923	10,834	not available
c. diagnostic		not available	not available	31,786	33,670	not available
d. other		not available	not available	not applicable	not applicable	not applicable
e. total		108,270,000	113,161,000	115,209,000	116,490,000	117,928,000
37. Average payment per service for insured (fee-for-service) physician services, by type of physician:	($)					
a. general practitioners		15.61	16.80	17.05	18.49	18.89
b. specialists		27.97	29.36	29.79	31.60	33.90
c. other		not applicable	not applicable	not applicable	not applicable	not applicable
d. all physicians		21.52	23.04	23.36	25.01	26.32
38. Average payment per service for insured physician services, by category of service:	($)					
a. medical		not available	not available	not available	not available	not available
b. surgical		not available	not available	not available	not available	not available
c. diagnostic		not available	not available	not available	not available	not available
d. other		not applicable	not applicable	not applicable	not applicable	not available
e. all services		21.52	23.04	23.36	25.01	26.30

Insured Physician Services Provided to Residents in Another Province or Territory

		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
39. Number of services paid for out-of-province/territory, insured physician services (in Canada).	(#)	163,000	171,000	161,000	173,000	143,000
40. Total payments for out-of-province/territory insured physician services (in Canada).	($)	4,346,000	4,241,000	4,327,000	4,562,000	4,082,000
41. Average payment per service for out-of-province/territory insured physician services (in Canada).	($)	26.60	24.77	28.41	26.35	28.56

Insured Physician Services Provided Outside Canada

		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
42. Number of services paid for out-of-country, insured physician services.	(#)	4,000	4,000	4,000	6,000	4,000
43. Total payments for out-of-country insured physician services.	($)	94,000	65,000	107,000	424,000	67,000
44. Average payment per service for out-of-country insured physician services.	($)	22.41	17.25	19.61	70.16	16.37

Prince Edward Island

Registered Persons		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
1. Total number of persons registered under the health care insurance plan as of March 31st.	(#)	126,124	130,004	134,006	138,205	140,001

Insured Hospital Services Within Own Province or Territory		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care:	(#)					
a. acute care		7	7	7	7	7
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care		not applicable	not applicable	not applicable	not applicable	not applicable
e. surgical day care (out-patient)		not applicable	not applicable	not applicable	not applicable	not applicable
f. other		not applicable	not applicable	not applicable	not applicable	not applicable
g. total facilities		7	7	7	7	7
3. Number of staffed beds in all facilities providing insured hospital services, by type of bed:	(#)					
a. acute care		470	470	470	470	479
b. chronic care		57	57	57	57	57
c. rehabilitative care		20	20	20	20	20
d. out-patient diagnostic care		19	19	19	19	19
e. other		not applicable	not applicable	not applicable	not applicable	not applicable
f. total staffed beds		566	566	566	566	575
4. Approved bed complement for all facilities providing insured hospital services, by type of bed:	(#)					
a. acute care		470	470	470	470	479
b. chronic care		57	57	57	57	57
c. rehabilitative care		20	20	20	20	20
d. out-patient diagnostic care		19	19	19	19	19
e. other		not applicable	not applicable	not applicable	not applicable	not applicable
f. total approved bed complement		566	566	566	566	575

Insured Hospitals Services Within Own Province or Territory

		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
5. Number of separations from all facilities providing insured hospital services, by type of care:	(#)					
a. acute care		18,626	18,644	17,796	18,280	16,409
b. chronic care		not available	not available	not available	not available	not available[1]
c. rehabilitative care		347	377	360	329	336
d. out-patient diagnostic care		not available	not available	not available	not available	not available[1]
e. surgical day care (out-patient)		5,911	6,250	6,186	not available	not available[1]
f. alternative level of care		not available	not available	not available	267	274
g. newborns		not available	not available	not available	1,363	1,356
h. other		not applicable	not applicable	not applicable	not applicable	not applicable
i. total separations		24,884	25,271	24,342	20,239	18,375
6. Average length of in-patient stay in all facilities providing insured hospital services, by type of care:	(# of days)					
a. acute care		8.10	7.90	8.40	8.20	8.10
b. chronic care		not available	not available	not available	not available	not available[1]
c. rehabilitative care		19.00	19.00	18.00	20.00	13.00
d. newborns		not available	not available	not available	not available	4.00
e. other		not applicable	not applicable	not applicable	not applicable	not applicable
7. Payments to facilities providing insured hospital services, by the facility's primary type of care:	($)					
a. acute care		94,800,000	101,600,000	104,000,000	106,774,200	109,128,000
b. chronic care		not applicable	not applicable	not applicable	not applicable	900
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care		not applicable	not applicable	not applicable	not applicable	not applicable
e. surgical day care (out-patient)		not applicable	not applicable	not applicable	not applicable	not applicable
f. other		not applicable	not applicable	not applicable	not applicable	not applicable
g. total payments to facilities providing insured hospital services		94,800,000	101,600,000	104,000,000	106,774,200	109,128,900
8. Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care:	($)					
a. acute care		628.35	689.81	695.72	not available	not available
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. other		not applicable	not applicable	not applicable	not applicable	not applicable

[1] Regional Health Authorities do not provide this information to the Prince Edward Island Department of Health and Social Services, therefore data are not available.

Insured Hospital Services Within Own Province or Territory		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care:	($)					
a. acute care		not available	not available	not available	not available	not available [2]
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care		not available	not available	not available	not available	not available [2]
e. surgical day care (out-patient)		not available	not available	not available	not available	not available [2]
f. other		not applicable	not applicable	not applicable	not applicable	not applicable
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care:	($)					
a. acute care		not available	not available	not available	not available	not available [2]
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. other		not applicable	not applicable	not applicable	not applicable	not applicable
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care:	(#)					
a. private surgical facilities		not applicable	not applicable	not applicable	not applicable	not applicable
b. private diagnostic imaging facilities		not applicable	not applicable	not applicable	not applicable	not applicable
c. Total private for-profit health care facilities		not applicable	not applicable	not applicable	not applicable	not applicable
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care:	(#)					
a. private surgical facilities		not applicable	not applicable	not applicable	not applicable	not applicable
b. private diagnostic imaging facilities		not applicable	not applicable	not applicable	not applicable	not applicable
c. Total insured hospital services provided at private for-profit health care facilities		not applicable	not applicable	not applicable	not applicable	not applicable
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care:	($)					
a. private surgical facilities		not applicable	not applicable	not applicable	not applicable	not applicable
b. private diagnostic imaging facilities		not applicable	not applicable	not applicable	not applicable	not applicable
c. Total payments to private for-profit health care facilities		not applicable	not applicable	not applicable	not applicable	not applicable

[2] Payments to facilities are not separated by in-patient and out-patient services.

Insured Hospital Services Provided to Residents in Another Province or Territory		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
14. Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (in Canada).	(#)	1,904	2,279	1,812	not available [3]	2,220
15. Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (in Canada).	(#)	13,341	16,457	14,428	not available [3]	17,572
16. Total payments for out-of-province/territory, in-patient, insured hospital services (in Canada).	($)	11,300,000	12,300,000	10,600,000	not available [3]	9,417,000
17. Total payments for out-of-province/territory, out-patient, insured hospital services (in Canada).	($)	1,700,000	2,600,000	2,300,000	not available [3]	2,930,100
18. Average payment for out-of-province/territory, in-patient insured hospital services (in Canada).	($)	5,935.00	5,397.00	5,850.00	not available [3]	4,242.00
19. Average payment for out-of-province/territory, out-patient insured hospital services (in Canada).	($)	127.00	158.00	160.00	not available [3]	167.00

Insured Hospital Services Provided Outside Canada		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
20. Total number of claims paid for out-of-country, in-patient, insured hospital services.	(#)	48	27	21	not available [3]	26
21. Total number of claims paid for out-of-country, out-patient, insured hospital services.	(#)	211	102	106	not available [3]	85
22. Total payments for out-of-country, in-patient, insured hospital services.	($)	119,400	50,100	53,800	not available [3]	123,127
23. Total payments for out-of-country, out-patient, insured hospital services.	($)	76,600	11,700	21,700	not available [3]	13,702
24. Average payment for out-of-country, in-patient insured hospital services.	($)	2,488.00	1,856.00	2,561.00	not available [3]	4,736.00
25. Average payment for out-of-country, out-patient insured hospital services.	($)	363.00	115.00	205.00	not available [3]	161.00

[3] New Brunswick and Nova Scotia have changed their systems. Out-of-province and out-of-country data not available.

Insured Surgical-Dental Services Within Own Province or Territory

		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
26. Number of dentists participating in the health insurance plan.	(#)	1	2	2	2	2
27. Number of insured surgical-dental services provided by participating dentists.	(#)	411	400	176	145	176
28. Total payments to dentists for insured surgical-dental services.	($)	50,200	52,700	37,600	53,100	60,989
29. Average payment per service for insured surgical-dental services.	($)	122.00	132.00	214.00	366.00	347.00

Insured Physician Services Within Own Province or Territory

		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
30. Number of physicians participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners		97	98	99	101	101
b. specialists		75	72	74	75	75
c. other		not applicable	not applicable	not applicable	not applicable	not applicable
d. total		172	170	173	176	176
31. Number of physicians opted-out of the health insurance plan, by type of physician:	(#)					
a. general practitioners		not applicable	not applicable	not applicable	not applicable	not applicable
b. specialists		not applicable	not applicable	not applicable	not applicable	not applicable
c. other		not applicable	not applicable	not applicable	not applicable	not applicable
d. total		not applicable	not applicable	not applicable	not applicable	not applicable
32. Number of physicians not participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners		not applicable	not applicable	not applicable	not applicable	not applicable
b. specialists		not applicable	not applicable	not applicable	not applicable	not applicable
c. other		not applicable	not applicable	not applicable	not applicable	not applicable
d. total		not applicable	not applicable	not applicable	not applicable	not applicable

Insured Physician Services Within Own Province or Territory						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
33. Number of insured physician services provided, by type of physician (fee-for-service):	(#)					
a. general practitioners		834,740	869,320	848,816	861,112	816,197
b. specialists		394,912	422,483	415,130	409,917	358,600
c. other		not applicable	not applicable	not applicable	not applicable	not applicable
d. total		1,229,652	1,291,803	1,263,946	1,271,029	1,174,797
34. Number of insured physician services provided, by category of service:	(#)					
a. medical		141,594	158,836	154,930	152,796	107,683
b. surgical		138,667	146,186	144,947	143,940	140,020
c. diagnostic		114,651	117,461	115,253	113,181	110,897
d. other		834,740	869,320	848,816	861,112	816,197 [4]
e. total		1,229,652	1,291,803	1,263,946	1,271,029	1,174,797
35. Total payments to (fee-for-service) physicians for insured physician services, by type of physician:	($)					
a. general practitioners		14,800,000	15,000,000	15,700,000	15,800,000	16,588,900
b. specialists		15,600,000	16,200,000	17,100,000	17,200,000	15,559,600
c. other		not applicable	not applicable	not applicable	not applicable	not applicable
d. total		30,400,000	31,200,000	32,800,000	33,000,000	32,148,500
36. Total payments to physicians for insured physician services, by category of service:	($)					
a. medical		5,900,000	6,200,000	6,600,000	6,500,000	5,061,000
b. surgical		8,000,000	8,300,000	8,800,000	8,900,000	8,703,600
c. diagnostic		1,700,000	1,700,000	1,700,000	1,800,000	1,795,000
d. other		not applicable	not applicable	not applicable	15,800,000	16,588,900 [4]
e. total		30,400,000	31,200,000	32,800,000	33,000,000	32,148,500
37. Average payment per service for insured (fee-for-service) physician services, by type of physician:	($)					
a. general practitioners		18.00	17.00	18.00	18.00	20.00
b. specialists		40.00	38.00	41.00	42.00	43.00
c. other		not applicable	not applicable	not applicable	not applicable	not applicable
d. all physicians		25.00	24.00	26.00	26.00	27.00
38. Average payment per service for insured physician services, by category of service:	($)					
a. medical		42.00	39.00	43.00	43.00	47.00
b. surgical		58.00	57.00	61.00	62.00	62.00
c. diagnostic		15.00	15.00	15.00	15.00	16.00
d. other		not applicable	not applicable	not applicable	not applicable	20.00
e. all services		25.00	24.00	26.00	26.00	27.00

[4] Includes general practitioners.

Insured Physician Services Provided to Residents in Another Province or Territory		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
39. Number of services paid for out-of-province/territory, insured physician services (in Canada).	(#)	58,667	56,192	56,084	not available [3]	67,435
40. Total payments for out-of-province/territory insured physician services (in Canada).	($)	2,780,000	3,080,000	3,080,000	not available [3]	3,871,900
41. Average payment per service for out-of-province/territory insured physician services (in Canada).	($)	47.00	55.00	55.00	not available [3]	57.00

Insured Physician Services Provided Outside Canada		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
42. Number of services paid for out-of-country, insured physician services.	(#)	1,242	807	666	not available [3]	677
43. Total payments for out-of-country insured physician services.	($)	52,874	25,495	38,274	not available [3]	33,995
44. Average payment per service for out-of-country insured physician services.	($)	42.00	31.00	57.00	not available [3]	50.00

[3] New Brunswick and Nova Scotia have changed their systems. Out-of-province and out-of-country data not available.

Nova Scotia

Registered Persons					
	1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
1. Total number of persons registered under the health care insurance plan as of March 31st. (#)	933,324	937,587	944,487	948,389	950,525

Insured Hospital Services Within Own Province or Territory					
	1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care: (#)					
a. acute care	35	35	35	35	35
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care	not applicable	not applicable	not applicable	not applicable	not applicable
e. surgical day care (out-patient)	not applicable	not applicable	not applicable	not applicable	not applicable
f. other	not applicable	not applicable	not applicable	not applicable	not applicable
g. total facilities	35	35	35	35	35
3. Number of staffed beds in all facilities providing insured hospital services, by type of bed: (#)					
a. acute care	3,214 [1]	3,221 [1]	3,117 [1]	3,089 [1]	2,982 [1]
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care	not applicable	not applicable	not applicable	not applicable	not applicable
e. other	not applicable	not applicable	not applicable	not applicable	not applicable
f. total staffed beds	3,214	3,221	3,117	3,089	2,982
4. Approved bed complement for all facilities providing insured hospital services, by type of bed: (#)					
a. acute care	not applicable	not applicable	not applicable	not applicable	not applicable
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care	not applicable	not applicable	not applicable	not applicable	not applicable
e. other	not applicable	not applicable	not applicable	not applicable	not applicable
f. total approved bed complement	not applicable	not applicable	not applicable	not applicable	not applicable

[1] Includes rehabilitative care.

Insured Hospitals Services Within Own Province or Territory		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
5. Number of separations from all facilities providing insured hospital services, by type of care:	(#)					
a. acute care		108,536	106,954	104,509	98,209	93,878
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		928 [2]	846 [2]	779 [2]	792 [2]	827 [2]
d. out-patient diagnostic care		not available	not available	not available	not available	not available
e. surgical day care (out-patient)		86,014	89,046	93,700	96,832	96,797
f. alternative level of care		1,422	1,890	2,002	2,064	2,181
g. newborns		9,951	9,675	9,607	9,038	8,883
h. other		not available	133	138	150	155
i. total separations		205,429 [3]	206,521 [3]	208,594 [3]	204,871 [3]	200,385 [3]
6. Average length of in-patient stay in all facilities providing insured hospital services, by type of care:	# of days					
a. acute care		8.23	7.93	8.29	8.01	8.50
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		42.50	42.00	43.30	47.20	42.90
d. newborns		3.67	3.68	3.69	3.80	3.70
e. other		not available	125.00	159.41	147.08	111.80
7. Payments to facilities providing insured hospital services, by the facility's primary type of care: [4]	($)					
a. acute care		701,208,000	795,946,000	812,776,800	877,019,426	926,797,569
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care		not applicable	not applicable	not applicable	not applicable	not applicable
e. surgical day care (out-patient)		not applicable	not applicable	not applicable	not applicable	not applicable
f. other		not applicable	not applicable	not applicable	not applicable	not applicable
g. total payments to facilities providing insured hospital services		701,208,000	795,946,000	812,776,800	877,019,426	926,797,569
8. Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care:	($)					
a. acute care		435.85	391.55	391.55	391.55	643.00
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. other		not applicable	not applicable	not applicable	not applicable	not applicable

[2] Type 4 level of care.

[3] Excludes separations with alternative level of care and newborns days.

[4] $'s are paid to acute care facilities/DHAs only

Insured Hospital Services Within Own Province or Territory						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care:	($)					
a. acute care		80.00 [1]	110.00 [1]	110.00 [1]	110.00 [1]	242.00 [1]
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care		not applicable	not applicable	not applicable	not applicable	not applicable
e. surgical day care (out-patient)		not applicable	not applicable	not applicable	not applicable	not applicable
f. other		not applicable	not applicable	not applicable	not applicable	not applicable
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care:	($)					
a. acute care		3,413.12	3,653.90	3,896.10	4,354.29	not available
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. other		not applicable	not applicable	not applicable	not applicable	not applicable
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care:	(#)					
a. private surgical facilities		1	1	1	1	1
b. private diagnostic imaging facilities		not applicable	not applicable	not applicable	not applicable	not applicable
c. Total private for-profit health care facilities		1	1	1	1	1
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care:	(#)					
a. private surgical facilities		150	154	120	109	81
b. private diagnostic imaging facilities		not available	not available	not available	not available	not available
c. Total insured hospital services provided at private for-profit health care facilities		not available	not available	not available	not available	not available
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care:	($)					
a. private surgical facilities		18,271	18,572	15,677	14,627	10,926
b. private diagnostic imaging facilities		not available	not available	not available	not available	not available
c. Total payments to private for-profit health care facilities		not available	not available	not available	not available	not available

[1] Standard national rate for out-patient services.

Insured Hospital Services Provided to Residents in Another Province or Territory

		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
14. Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (in Canada).	(#)	2,331	2,395	2,382	2,520	2,050
15. Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (in Canada).	(#)	29,165	29,927	30,086	32,859	30,749
16. Total payments for out-of-province/territory, in-patient, insured hospital services (in Canada).	($)	8,864,423	10,395,116	10,499,281	9,961,995	8,536,691
17. Total payments for out-of-province/territory, out-patient, insured hospital services (in Canada).	($)	3,038,860	3,770,060	3,772,315	4,171,365	4,009,667
18. Average payment for out-of-province/territory, in-patient insured hospital services (in Canada).	($)	3,802.84	4,340.34	4,407.75	3,953.17	4,115.45
19. Average payment for out-of-province/territory, out-patient insured hospital services (in Canada).	($)	104.20	125.98	125.38	126.94	130.39

Insured Hospital Services Provided Outside Canada

		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
20. Total number of claims paid for out-of-country, in-patient, insured hospital services.	(#)	not available	not available	not available	not available	not available
21. Total number of claims paid for out-of-country, out-patient, insured hospital services.	(#)	not applicable	not applicable	not applicable	not applicable	not applicable
22. Total payments for out-of-country, in-patient, insured hospital services.	($)	851,689	859,642	1,053,577	736,104	1,000,023
23. Total payments for out-of-country, out-patient, insured hospital services.	($)	not applicable	not applicable	not applicable	not applicable	not applicable
24. Average payment for out-of-country, in-patient insured hospital services.	($)	not available	not available	not available	not available	not available
25. Average payment for out-of-country, out-patient insured hospital services.	($)	not applicable	not applicable	not applicable	not applicable	not applicable

Insured Surgical-Dental Services Within Own Province or Territory						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
26. Number of dentists participating in the health insurance plan.	(#)	53	54	55	39	35
27. Number of insured surgical-dental services provided by participating dentists.	(#)	15,549	16,909	17,525	6,853	4,497
28. Total payments to dentists for insured surgical-dental services.	($)	1,515,311	1,726,646	1,467,485	998,692	884,506
29. Average payment per service for insured surgical-dental services.	($)	97.45	102.11	83.74	144.27	196.69

Insured Physician Services Within Own Province or Territory						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
30. Number of physicians participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners		not available	not available	829	920	865
b. specialists		not available	not available	1,102	1,067	1,128
c. other		0	0	0	0	10
d. total		1,836	1,853	1,931	1,987	2,003
31. Number of physicians opted-out of the health insurance plan, by type of physician:	(#)					
a. general practitioners		0	0	0	0	0
b. specialists		0	0	0	0	0
c. other		0	0	0	0	0
d. total		0	0	0	0	0
32. Number of physicians not participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners		0	0	0	0	0
b. specialists		0	0	0	0	0
c. other		0	0	0	0	0
d. total		0	0	0	0	0

Insured Physician Services Within Own Province or Territory

		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
33. Number of insured physician services provided, by type of physician (fee-for-service):	(#)					
a. general practitioners		4,443,772	4,334,359	4,619,083	4,498,232	4,521,991
b. specialists		1,854,669	1,794,146	1,606,842	1,645,535	1,650,685
c. other		0	0	0	3,951	2,999
d. total		6,298,441	6,128,505	6,225,925	6,147,718	6,175,675
34. Number of insured physician services provided, by category of service: [7]	(#)					
a. medical		not available	not available	not available	not available	not available
b. surgical		not available	not available	not available	not available	not available
c. diagnostic		not available	not available	not available	not available	not available
d. other		not available	not available	not available	not available	not available
e. total		8,386,447	8,486,514	8,860,045	8,839,088	8,913,220
35. Total payments to (fee-for-service) physicians for insured physician services, by type of physician: [6]	($)					
a. general practitioners		91,782,118	91,620,190	104,587,110	102,332,556	102,555,964
b. specialists		115,725,195	118,656,216	112,250,617	117,891,477	118,414,434
c. other		0	0	0	175,890	162,779
d. total		207,507,313	210,276,406	216,837,727	220,399,923	221,133,176
36. Total payments to physicians for insured physician services, by category of service: [6,7]	($)					
a. medical		not available	not available	not available	239,036,017	244,049,190
b. surgical		not available	not available	not available	77,328,861	80,867,051
c. diagnostic		not available	not available	not available	25,385,064	26,262,276
d. other		not available	not available	not available	7,287,248	8,015,345
e. total		296,138,155	317,320,281	350,091,235	349,037,190	359,193,862
37. Average payment per service for insured (fee-for-service) physician services, by type of physician:	($)					
a. general practitioners		20.65	21.14	22.64	22.75	22.68
b. specialists		62.40	66.14	69.86	71.64	71.74
c. other		0.00	0.00	0.00	44.52	54.28
d. all physicians		32.95	34.31	34.83	35.85	35.81
38. Average payment per service for insured physician services, by category of service: [7]	($)					
a. medical		not available	not available	not available	not available	not available
b. surgical		not available	not available	not available	not available	not available
c. diagnostic		not available	not available	not available	not available	not available
d. other		not available	not available	not available	not available	not available
e. all services		35.31	35.39	39.51	39.51	40.30

[6] Discrepancies may exist between data presented here and the Nova Scotia Annual Statistical Tables due to methodological differences.

[7] Fee- for- service + alternate funded programs.

Insured Physician Services Provided to Residents in Another Province or Territory						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
39. Number of services paid for out-of-province/territory, insured physician services (in Canada).	(#)	not available	not available	not available	180,299	179,833
40. Total payments for out-of-province/territory insured physician services (in Canada).	($)	not available	not available	not available	4,766,189	5,078,794
41. Average payment per service for out-of-province/territory insured physician services (in Canada).	($)	not available	not available	not available	26.43	28.24

Insured Physician Services Provided Outside Canada						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
42. Number of services paid for out-of-country, insured physician services.	(#)	not available	not available	not available	2,541	2,421
43. Total payments for out-of-country insured physician services.	($)	not available	not available	not available	98,461	109,484
44. Average payment per service for out-of-country insured physician services.	($)	not available	not available	not available	38.75	45.22

New Brunswick

Registered Persons						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
1. Total number of persons registered under the health care insurance plan as of March 31st.	(#)	742,218	735,510	739,336	738,598	737,299

Insured Hospital Services Within Own Province or Territory						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care:	(#)					
a. acute care		31	31	31	31	31
b. chronic care		0	0	0	0	0
c. rehabilitative care		1	1	1	1	1
d. out-patient diagnostic care		0	0	0	0	0
e. surgical day care (out-patient)		0	0	0	0	0
f. other		0	0	0	0	0
g. total facilities		32	32	32	32	32
3. Number of staffed beds in all facilities providing insured hospital services, by type of bed:	(#)					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. out-patient diagnostic care		not available	not available	not available	not available	not available
e. other		not available	not available	not available	not available	not available
f. total staffed beds		not available	not available	not available	not available	not available
4. Approved bed complement for all facilities providing insured hospital services, by type of bed:	(#)					
a. acute care		3,036	3,036	3,036	3,036	3,036
b. chronic care		397	397	397	397	397
c. rehabilitative care		20	20	20	20	20
d. out-patient diagnostic care		0	0	0	0	0
e. other		0	0	0	0	0
f. total approved bed complement		3,453	3,453	3,453	3,453	3,453

Insured Hospitals Services Within Own Province or Territory

		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
5. Number of separations from all facilities providing insured hospital services, by type of care:	(#)					
a. acute care		110,865	109,542	108,353	102,465	102,465
b. chronic care		2,280	2,398	2,281	1,887	1,887
c. rehabilitative care		457	411	444	465	465
d. out-patient diagnostic care		0	0	0	0	0
e. surgical day care (out-patient)		44,597	42,962	46,287	46,345	46,345
f. alternative level of care		246	307	308	342	342
g. newborns		8,050	7,939	7,778	7,455	7,455
h. other		0	0	0	0	0
i. total separations		160,495	163,559	165,451	158,959	158,959
6. Average length of in-patient stay in all facilities providing insured hospital services, by type of care:	(# of days)					
a. acute care		6.60	6.80	6.80	7.10	7.10
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		39.10	47.30	41.30	41.20	41.20
d. newborns		not available	not available	not available	not available	not available
e. other		not available	not available	not available	not available	not available
7. Payments to facilities providing insured hospital services, by the facility's primary type of care:	($)					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. out-patient diagnostic care		not available	not available	not available	not available	not available
e. surgical day care (out-patient)		not available	not available	not available	not available	not available
f. other		not available	not available	not available	not available	not available
g. total payments to facilities providing insured hospital services		629,964,593	639,764,216	674,487,768	not available	not available
8. Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care:	($)					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. other		not available	not available	not available	not available	not available

Insured Hospital Services Within Own Province or Territory						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care:	($)					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. out-patient diagnostic care		not available	not available	not available	not available	not available
e. surgical day care (out-patient)		not available	not available	not available	not available	not available
f. other		not available	not available	not available	not available	not available
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care:	($)					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. other		not available	not available	not available	not available	not available
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care:	(#)					
a. private surgical facilities		not applicable	not applicable	not applicable	not applicable	not applicable
b. private diagnostic imaging facilities		not applicable	not applicable	not applicable	not applicable	not applicable
c. Total private for-profit health care facilities		not applicable	not applicable	not applicable	not applicable	not applicable
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care:	(#)					
a. private surgical facilities		not available	not available	not available	not available	not available
b. private diagnostic imaging facilities		not available	not available	not available	not available	not available
c. Total insured hospital services provided at private for-profit health care facilities		not available	not available	not available	not available	not available
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care:	($)					
a. private surgical facilities		not available	not available	not available	not available	not available
b. private diagnostic imaging facilities		not available	not available	not available	not available	not available
c. Total payments to private for-profit health care facilities		not available	not available	not available	not available	not available

Insured Hospital Services Provided to Residents in Another Province or Territory						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
14. Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (in Canada).	(#)	3,566 pts / 24,993 days	3,768 pts / 24,915 days	3,900 pts / 25,655 days	4,130 pts / 26,572 days	3,796 pts / 23,342 days
15. Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (in Canada).	(#)	31,684	36,081	32,796	35,834	36,687
16. Total payments for out-of-province/territory, in-patient, insured hospital services (in Canada).	($)	21,515,090	21,863,730	22,473,974	21,561,907	19,110,500
17. Total payments for out-of-province/territory, out-patient, insured hospital services (in Canada).	($)	3,295,272	4,374,860	4,235,429	4,702,219	5,261,500
18. Average payment for out-of-province/territory, in-patient insured hospital services (in Canada).	($)	860.84	877.53	876.01	811.45	818.72
19. Average payment for out-of-province/territory, out-patient insured hospital services (in Canada).	($)	104.00	121.25	129.14	131.22	143.42

Insured Hospital Services Provided Outside Canada						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
20. Total number of claims paid for out-of-country, in-patient, insured hospital services.	(#)	190 pts / 788 days	145 pts / 661 days	212 pts / 1,691 days	166 pts / 1,096 days	148 pts / 1,447days
21. Total number of claims paid for out-of-country, out-patient, insured hospital services.	(#)	881	395	524	639	1,003
22. Total payments for out-of-country, in-patient, insured hospital services.	($)	385,548	150,403	487,760	458,759	440,088
23. Total payments for out-of-country, out-patient, insured hospital services.	($)	101,585	85,443	105,783	180,712	133,360
24. Average payment for out-of-country, in-patient insured hospital services.	($)	489.27	227.54	288.44	418.58	304.14
25. Average payment for out-of-country, out-patient insured hospital services.	($)	115.31	216.31	201.88	282.80	132.96

Insured Surgical-Dental Services Within Own Province or Territory						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
26. Number of dentists participating in the health insurance plan.	(#)	14	17	12	16	12
27. Number of insured surgical-dental services provided by participating dentists.	(#)	632	790	751	1,004	1,010
28. Total payments to dentists for insured surgical-dental services.	($)	119,524	132,577	136,491	189,777	186,944
29. Average payment per service for insured surgical-dental services.	($)	189.12	167.82	181.75	189.02	185.09

Insured Physician Services Within Own Province or Territory						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
30. Number of physicians participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners		581	619	629	645	689
b. specialists		682	709	721	710	799
c. other		not available	not available	not available	not available	not available
d. total		1,263	1,328	1,350	1,355	1,488
31. Number of physicians opted-out of the health insurance plan, by type of physician:	(#)					
a. general practitioners		0	0	0	0	0
b. specialists		0	0	0	0	0
c. other		0	0	0	0	0
d. total		0	0	0	0	0
32. Number of physicians not participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners		0	0	0	0	0
b. specialists		0	0	0	0	0
c. other		0	0	0	0	0
d. total		0	0	0	0	0

Insured Physician Services Within Own Province or Territory						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
33. Number of insured physician services provided, by type of physician (fee-for-service):	(#)					
a. general practitioners		3,625,877	3,692,566	3,721,782	3,668,781	3,611,747
b. specialists		2,479,186	2,551,663	2,612,744	2,590,346	1,549,622[1]
c. other		not available	not available	not available	not available	not available
d. total		6,105,063	6,244,229	6,334,526	6,259,127	5,161,369
34. Number of insured physician services provided, by category of service:	(#)					
a. medical		686,896	729,803	739,911	728,947	723,280
b. surgical		827,458	828,626	852,725	839,980	826,342
c. diagnostic		964,832[2]	993,234[2]	1,020,108[2]	1,021,419[2]	not available
d. other		3,625,877	3,692,566	3,721,782	3,668,781	3,611,747
e. total		6,105,063	6,244,229	6,334,526	5,237,708	5,161,369
35. Total payments to (fee-for-service) physicians for insured physician services, by type of physician:	($)					
a. general practitioners		74,575,504	77,851,628	77,958,130	78,139,070	85,584,720
b. specialists		100,834,441	104,752,866	111,554,173	111,224,207	96,145,451
c. other		not available	not available	not available	not available	not available
d. total		175,409,945	182,604,494	189,512,303	189,363,277	181,730,171
36. Total payments to physicians for insured physician services, by category of service:	($)					
a. medical		37,548,393	40,384,442	41,795,791	41,068,744	44,041,949
b. surgical		46,574,724	46,871,179	48,732,272	47,840,045	52,103,502
c. diagnostic		16,711,324[2]	17,497,245[2]	21,026,109[2]	22,315,418[2]	not available[2]
d. other		74,575,504[3]	77,851,628[3]	77,958,130[3]	78,139,070[3]	85,584,720[3]
e. total		175,409,945	182,604,494	189,512,302	189,363,277	181,730,171
37. Average payment per service for insured (fee-for-service) physician services, by type of physician:	($)					
a. general practitioners		20.57	21.08	20.95	21.30	23.70
b. specialists		40.67	41.05	42.70	42.94	62.04
c. other		not available	not available	not available	not available	not available
d. all physicians		28.73	29.24	29.92	30.25	35.21
38. Average payment per service for insured physician services, by category of service:	($)					
a. medical		54.66	55.34	56.49	56.34	60.89
b. surgical		56.29	56.56	57.15	56.95	63.05
c. diagnostic		17.32[2]	17.62[2]	20.61[2]	21.85[2]	not available[2]
d. other		20.57[3]	21.08[3]	20.95[3]	21.30[3]	23.70[3]
e. all services		28.73	29.24	29.92	36.15	35.21

[1] Radiology data are incomplete for fiscal year 2000-2001.

[2] Radiology only.

[3] Includes general practitioners.

Insured Physician Services Provided to Residents in Another Province or Territory						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
39. Number of services paid for out-of-province/territory, insured physician services (in Canada).	(#)	153,230	140,375	137,950	141,014	136,353
40. Total payments for out-of-province/territory insured physician services (in Canada).	($)	6,186,476	5,684,969	6,050,729	6,280,048	8,257,500
41. Average payment per service for out-of-province/territory insured physician services (in Canada).	($)	40.37	40.50	43.86	44.53	60.56

Insured Physician Services Provided Outside Canada						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
42. Number of services paid for out-of-country, insured physician services.	(#)	7,283	3,835	4,554	4,202	4,220
43. Total payments for out-of-country insured physician services.	($)	366,996	223,066	356,128	362,994	332,600
44. Average payment per service for out-of-country insured physician services.	($)	50.39	58.17	78.20	86.39	78.82

Ontario

Registered Persons		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
1. Total number of persons registered under the health care insurance plan as of March 31st [1]	(#)	11.2 M [2]	11.3 M [2]	11.4 M [2]	11.7 M [2]	11.9 M [2]

Insured Hospital Services Within Own Province or Territory		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care:	(#)					
a. acute care		179	157	154	150	139
b. chronic care		25	22	12	11	11
c. rehabilitative care		6	5	4	4	4
d. out-patient diagnostic care		not available [3]	not available [3]	not available [3]	not available [3]	not available [3]
e. surgical day care (out-patient)		not available [4]	not available [4]	not available [4]	not available [4]	not available [4]
f. other		4	4	3	3	3
g. total facilities		not available [5]	not available [5]	not available [5]	not available [5]	not available [5]
3. Number of staffed beds in all facilities providing insured hospital services, by type of bed:	(#)					
a. acute care		24,505	23,872	24,254	25,008	24,233
b. chronic care		8,148	7,787	7,505	7,405	7,389
c. rehabilitative care		1,815	1,822	1,975	2,137	2,270
d. out-patient diagnostic care		not available [3]	not available [3]	not available [3]	not available [3]	not available [3]
e. other		not available [6]	not available [6]	not available [6]	not available [6]	not available [6]
f. total staffed beds		not available [5]	not available [5]	not available [5]	not available [5]	not available [5]
4. Approved bed complement for all facilities providing insured hospital services, by type of bed:	(#)					
a. acute care		not available [7]	not available [7]	not available [7]	not available [7]	not available [7]
b. chronic care		not available [7]	not available [7]	not available [7]	not available [7]	not available [7]
c. rehabilitative care		not available [7]	not available [7]	not available [7]	not available [7]	not available [7]
d. out-patient diagnostic care		not available [7]	not available [7]	not available [7]	not available [7]	not available [7]
e. other		not available [7]	not available [7]	not available [7]	not available [7]	not available [7]
f. total approved bed complement		not available [7]	not available [7]	not available [7]	not available [7]	not available [7]

[1] These estimates represent the number of individuals registered for Ontario health coverage with valid and active health numbers as of December 31 2001. Data for 2002 are not available.

[2] M = Millions.

[3] Ontario does not have facilities in these categories. These types of facilities are privately owned and any insured services provided are covered by the province.

[4] Day surgery only reports cases and the stretchers are not reported whereas acute, chronic and rehabilitative units report beds and have separations.

[5] Total is not available since some of the items in the list are not available.

[6] Details for other types of beds are not kept separately, they are included as part of the acute, chronic and rehabilitation beds reporting.

[7] Not available - there is no central repository for this information.

Insured Hospitals Services Within Own Province or Territory					
	1997-1998	**1998-1999**	**1999-2000**	**2000-2001**	**2001-2002**
5. Number of separations from all facilities providing insured hospital services, by type of care: (#)					
a. acute care	1,041,004	1,131,333	1,007,464	1,004,042	1,011,283
b. chronic care	18,426	17,165	18,943	19,777	20,432
c. rehabilitative care	18,513	188,865	20,837	20,236	27,004
d. out-patient diagnostic care	not available [8]	not available [8]	not available [8]	not available [8]	not available [8]
e. surgical day care (out-patient)	879,826	896,833	943,045	983,916	1,012,618
f. alternative level of care	not available [8]	not available [8]	not available [8]	not available [8]	not available [8]
g. newborns	137,114	134,505	134,136	130,062	134,475
h. other	not available [8]	not available [8]	not available [8]	not available [8]	not available [8]
i. total separations	not available [5]	not available [5]	not available [5]	not available [5]	not available [5]
6. Average length of in-patient stay in all facilities providing insured hospital services, by type of care: (# of days)					
a. acute care	6.44 [9]	6.52 [9]	6.59 [9]	6.95 [9]	7.50 [9]
b. chronic care	140.79 [9]	129.10 [9]	128.87 [9]	118.13 [9]	114.93 [9]
c. rehabilitative care	32.30	30.30	29.85	26.32	26.45
d. newborns	2.88	2.83	2.90	2.96	2.91
e. other	not available [10]	not available [10]	not available [10]	not available [10]	not available [10]
7. Payments to facilities providing insured hospital services, by the facility's primary type of care: ($)					
a. acute care	not available [11]	not available [11]	not available [11]	not available [11]	not available [11]
b. chronic care	not available [11]	not available [11]	not available [11]	not available [11]	not available [11]
c. rehabilitative care	not available [11]	not available [11]	not available [11]	not available [11]	not available [11]
d. out-patient diagnostic care	not available [11]	not available [11]	not available [11]	not available [11]	not available [11]
e. surgical day care (out-patient)	not available [11]	not available [11]	not available [11]	not available [11]	not available [11]
f. other	not available [11]	not available [11]	not available [11]	not available [11]	not available [11]
g. total payments to facilities providing insured hospital services	6.7 B [12]	7.1 B [12]	7.5 B [12]	8.0 B [12]	9.2 B [12]
8. Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care: ($)					
a. acute care	654.00	691.00	761.00	not available [13]	not available [13]
b. chronic care	266.00	274.00	287.00	not available [13]	not available [13]
c. rehabilitative care	369.00	385.00	436.00	not available [13]	not available [13]
d. other	not available [10]	not available [10]	not available [10]	not available [10]	not available [10]

[5] Total is not available since some of the items in the list are not available.

[8] Not available - the data is not collected by these classifications -e.g. alternative level of care is included with acute separations.

[9] Data has been revised - acute length of stay previously omitted acute mental health patients - chronic data was reviewed and revised to match internal reporting.

[10] Other types of care are not segregated.

[11] a) Facilities in Ontario tend to be mixed (acute/chronic, chronic/rehabilitative beds) with only a minority having one type of bed.

b) Separating by facility type gives a small sample size and significantly understates the amount actually spent on chronic and rehabilitative beds.

[12] B = Billion.

[13] Data not available at time of report production.

Insured Hospital Services Within Own Province or Territory						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care:	($)					
a. acute care		not available [14]	not available [14]	not available [14]	not available [14]	not available [14]
b. chronic care		not available [14]	not available [14]	not available [14]	not available [14]	not available [14]
c. rehabilitative care		not available [14]	not available [14]	not available [14]	not available [14]	not available [14]
d. out-patient diagnostic care		not available [14]	not available [14]	not available [14]	not available [14]	not available [14]
e. surgical day care (out-patient)		not available [14]	not available [14]	not available [14]	not available [14]	not available [14]
f. other		not available [14]	not available [14]	not available [14]	not available [14]	not available [14]
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care:	($)					
a. acute care		not available [14]	not available [14]	not available [14]	not available [14]	not available [14]
b. chronic care		not available [14]	not available [14]	not available [14]	not available [14]	not available [14]
c. rehabilitative care		not available [14]	not available [14]	not available [14]	not available [14]	not available [14]
d. other		not available [14]	not available [14]	not available [14]	not available [14]	not available [14]
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care:	(#)					
a. private surgical facilities		not available [15]	not available [15]	not available [15]	not available [15]	not available [15]
b. private diagnostic imaging facilities		not available [15]	not available [15]	not available [15]	not available [15]	not available [15]
c. Total private for-profit health care facilities		not available [15]	not available [15]	not available [15]	not available [15]	not available [15]
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care:	(#)					
a. private surgical facilities		not available [15]	not available [15]	not available [15]	not available [15]	not available [15]
b. private diagnostic imaging facilities		not available [15]	not available [15]	not available [15]	not available [15]	not available [15]
c. Total insured hospital services provided at private for-profit health care facilities		not available [15]	not available [15]	not available [15]	not available [15]	not available [15]
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care:	($)					
a. private surgical facilities		not available [15]	not available [15]	not available [15]	not available [15]	not available [15]
b. private diagnostic imaging facilities		not available [15]	not available [15]	not available [15]	not available [15]	not available [15]
c. Total payments to private for-profit health care facilities		not available [15]	not available [15]	not available [15]	not available [15]	not available [15]

[14] Not available - the reliability of the data is questionable and the results of the calculations are questionable and are not supportable or reportable.

a) Facilities in Ontario tend to be mixed (acute/chronic, chronic/rehabilitative beds) with only a minority having one type of activity.

b) Separating by facility type gives a small sample size and significantly understates the amount of activity related to chronic and rehabilitative outpatients.

c) Mergers and amalgamations during this period also contribute variability to the figures particularly when viewed by main activity.

[15] Not available - the data is not collected within a single system in the ministry.

Insured Hospital Services Provided to Residents in Another Province or Territory

		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
14. Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (in Canada).	(#)	8,004	8,431	9,031	9,540	8,633
15. Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (in Canada).	(#)	102,504	104,398	155,648	161,882	144,831
16. Total payments for out-of-province/territory, in-patient, insured hospital services (in Canada).	($)	36.2 M	32.8 M	41.3 M	39.9 M	36.8 M
17. Total payments for out-of-province/territory, out-patient, insured hospital services (in Canada).	($)	10.7 M	13.3 M	18.7 M	22.0 M	18.0 M
18. Average payment for out-of-province/territory, in-patient insured hospital services (in Canada).	($)	4,523.00	3,890.00	4,573.00	4,182.00	4,262.70
19. Average payment for out-of-province/territory, out-patient insured hospital services (in Canada).	($)	104.00	127.00	120.00	136.00	124.30

Insured Hospital Services Provided Outside Canada

		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
20. Total number of claims paid for out-of-country, in-patient, insured hospital services.	(#)	26,211	24,141	20,657	20,503	18,542
21. Total number of claims paid for out-of-country, out-patient, insured hospital services.	(#)	included in #20	included in #20	included in #20	included in #20	included in #20
22. Total payments for out-of-country, in-patient, insured hospital services.	($)	25.0 M	21.4 M	17.0 M	18.8 M	19.3 M
23. Total payments for out-of-country, out-patient, insured hospital services.	($)	included in #22	included in #22	included in #22	included in #22	included in #22
24. Average payment for out-of-country, in-patient insured hospital services.	($)	954.00	886.00	823.00	918.00	1,043.20
25. Average payment for out-of-country, out-patient insured hospital services.	($)	included in #24	included in #24	included in #24	included in #24	included in #24

Insured Surgical-Dental Services Within Own Province or Territory						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
26. Number of dentists participating in the health insurance plan.	(#)	366	350	350 [16]	357	327
27. Number of insured surgical-dental services provided by participating dentists.	(#)	69,163	70,658	69,400	71,660	74,000
28. Total payments to dentists for insured surgical-dental services.	($)	7.9 M	7.9 M	8.1 M	8.2 M	8.6 M
29. Average payment per service for insured surgical-dental services.	($)	114.22	111.80	116.71	115.21	116.00

Insured Physician Services Within Own Province or Territory						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
30. Number of physicians participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners		10,319	10,221	10,227	10,281	10,395
b. specialists		9,944	9,994	10,284	10,392	10,520
c. other		not available [17]	not available [17]	not available [17]	not available [17]	not available [17]
d. total		20,263	20,215	20,511	20,673	20,915
31. Number of physicians opted-out of the health insurance plan, by type of physician:	(#)					
a. general practitioners		29	26	25	25	22
b. specialists		209	196	188	177	165
c. other		not available [17]	not available [17]	not available [17]	not available [17]	not available [17]
d. total		238	222	213	202	187
32. Number of physicians not participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners		not available [18]	not available [18]	not available [18]	not available [18]	not available [18]
b. specialists		not available [18]	not available [18]	not available [18]	not available [18]	not available [18]
c. other		not available [18]	not available [18]	not available [18]	not available [18]	not available [18]
d. total		not available [18]	not available [18]	not available [18]	not available [18]	not available [18]

[16] Number of participating dentists was 350, but over 700 are registered on the Corporate Provider Database.

[17] All physicians are categorized within general practitioner, specialist and within medical, surgical or diagnostic.

[18] Ontario has no non-participating physicians, only opted-out physicians who are reported under item #31.

Insured Physician Services Within Own Province or Territory

		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
33. Number of insured physician services provided, by type of physician (fee-for-service):	(#)					
a. general practitioners		83.6 M	80.4 M	79.6 M	79.7 M	77.8 M
b. specialists		90.8 M	89.9 M	91.4 M	93.6 M	99.6 M
c. other		not available[17]	not available[17]	not available[17]	not available[17]	not available[17]
d. total		174.4 M	170.3 M	171.0 M	173.3 M	177.4 M
34. Number of insured physician services provided, by category of service:	(#)					
a. medical		85.3 M	84.2 M	84.1 M	82.9 M	81.8 M
b. surgical		22.2 M	21.6 M	22.0 M	22.3 M	22.7 M
c. diagnostic		66.8 M	64.4 M	64.8 M	68.1 M	72.9 M
d. other		not available[17]	not available[17]	not available[17]	not available[17]	not available[17]
e. total		174.3 M	170.2 M	170.9 M	173.3 M	177.4 M
35. Total payments to (fee-for-service) physicians for insured physician services, by type of physician:	($)					
a. general practitioners		1,722.7 M	1,676.9 M	1,725.2 M	1,734.1 M	1,741.4 M
b. specialists		2,618.6 M	2,587.2 M	2,699.2 M	2,824.3 M	2,936.7 M
c. other		not available[17]	not available[17]	not available[17]	not available[17]	not available[17]
d. total		4341.3 M	4264.1 M	4424.4 M	4,558.4 M	4,678.1 M
36. Total payments to physicians for insured physician services, by category of service:	($)					
a. medical		2,664.5 M	2,605.6 M	2,678.6 M	2,699.8 M	2,731.4 M
b. surgical		616.0 M	608.5 M	633.8 M	670.8 M	706.8 M
c. diagnostic		1,060.8 M	1,050.1 M	1,112.0 M	1,187.8 M	1,239.8 M
d. other		not available[17]	not available[17]	not available[17]	not available[17]	not available[17]
e. total		4,341.3 M	4,264.2 M	4,424.4 M	4,558.4 M	4,678.1 M
37. Average payment per service for insured (fee-for-service) physician services, by type of physician:	($)					
a. general practitioners		20.61	20.86	21.67	21.77	22.40
b. specialists		28.84	28.78	29.53	30.19	29.50
c. other		not available[17]	not available[17]	not available[17]	not available[17]	not available[17]
d. all physicians		24.89	25.05	25.87	26.32	26.40
38. Average payment per service for insured physician services, by category of service:	($)					
a. medical		31.24	30.94	31.84	32.59	33.40
b. surgical		27.72	28.19	28.78	30.09	31.10
c. diagnostic		15.87	16.30	17.15	17.45	17.00
d. other		not available[17]	not available[17]	not available[17]	not available[17]	not available[17]
e. all services		24.90	25.05	25.87	26.32	26.40

[17] All physicians are categorized within general practitioner, specialist and within medical, surgical or diagnostic.

Insured Physician Services Provided to Residents in Another Province or Territory

		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
39. Number of services paid for out-of-province/territory, insured physician services (in Canada).	(#)	428,329	433,396	455,136	433,463	469,146
40. Total payments for out-of-province/territory insured physician services (in Canada).	($)	12.8 M	13.3 M	14.0 M	14.3 M	15.5 M
41. Average payment per service for out-of-province/territory insured physician services (in Canada).	($)	30.00	31.00	31.00	33.00	33.00

Insured Physician Services Provided Outside Canada

		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
42. Number of services paid for out-of-country, insured physician services.	(#)	228,379	207,736	184,107	179,679	157,191
43. Total payments for out-of-country insured physician services.	($)	7.5 M	7.0 M	11.6 M	15.5 M	8.2 M
44. Average payment per service for out-of-country insured physician services.	($)	33.00	34.00	63.00	86.00	51.90

Manitoba

Registered Persons [1]

		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
1. Total number of persons registered under the health care insurance plan as of March 31st.	(#)	1,146,331	1,142,465	1,144,424	1,149,904	1,152,982

Insured Hospital Services Within Own Province or Territory

		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care:	(#)					
a. acute care		95	95	95	95	96
b. chronic care		4[2]	4[2]	4[2]	3[2]	3[2]
c. rehabilitative care		not available	not available	not available	not available	not available
d. out-patient diagnostic care		not applicable	not applicable	not applicable	not applicable	not applicable
e. surgical day care (out-patient)		not applicable	not applicable	not applicable	not applicable	not applicable
f. other		not applicable	not applicable	not applicable	not applicable	not applicable
g. total facilities		99	99	99	98	99
3. Number of staffed beds in all facilities providing insured hospital services, by type of bed: [3]	(#)					
a. acute care		4,559	4,436	4,394	4,406	4,595
b. chronic care		392[2]	402[2]	402[2]	385[2]	385[2]
c. rehabilitative care		not available	not available	not available	not available	not available
d. out-patient diagnostic care		not available	not available	not available	not available	not available
e. other		not available	not available	not available	not available	not available
f. total staffed beds		not available	not available	not available	not available	4,980
4. Approved bed complement for all facilities providing insured hospital services, by type of bed: [3]	(#)					
a. acute care		4,559	4,439	4,394	4,406	4,595
b. chronic care		392[2]	402[2]	402[2]	385[2]	385[2]
c. rehabilitative care		not available	not available	not available	not available	not available
d. out-patient diagnostic care		not available	not available	not available	not available	not available
e. other		not available	not available	not available	not available	not available
f. total approved bed complement		4,951	4,841	4,796	4,791	4,980

[1] The population data is based on records of residents registered with Manitoba Health as at June 1.

[2] Includes both chronic care and rehabilitative care.

[3] The number of beds that are set up as of March 31 for patient accommodation by a hospital.

Insured Hospitals Services Within Own Province or Territory						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
5. Number of separations from all facilities providing insured hospital services, by type of care:	(#)					
a. acute care		136,931	136,499	132,650	127,903	124,989
b. chronic care		1,746	1,757	1,876	1,905	1,708
c. rehabilitative care		not available	not available	not available	not available	not available
d. out-patient diagnostic care		not available	not available	not available	not available	not available
e. surgical day care (out-patient)		107,418	111,931	115,136	116,305	145,690
f. alternative level of care		not available	not available	not available	not available	not available
g. newborns		14,784	14,814	14,807	14,403	14,333
h. other		not available	not available	not available	not available	not available
i. total separations		260,879	265,001	264,469	260,516	not available
6. Average length of in-patient stay in all facilities providing insured hospital services, by type of care:	(# of days)					
a. acute care		9.27	9.49	9.72	9.91	9.10
b. chronic care		118.03[2]	74.30[2]	69.04[2]	78.40[2]	72.19
c. rehabilitative care		not available	not available	not available	not available	not available
d. newborns		3.73	3.89	3.47	3.47	3.33
e. other		not available	not available	not available	not available	not available
7. Payments to facilities providing insured hospital services, by the facility's primary type of care:	($)					
a. acute care		not available	not available	not available	953,834,797	1,046,407,229
b. chronic care		not available	not available	not available	65,153,895	70,872,152
c. rehabilitative care		not available	not available	not available	not available	not available
d. out-patient diagnostic care		not available	not available	not available	not available	not available
e. surgical day care (out-patient)		not available	not available	not available	not available	not available
f. other		not available	not available	not available	not available	not available
g. total payments to facilities providing insured hospital services		not available	not available	not available	not available	not available
8. Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care:	($)					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. other		not available	not available	not available	not available	not available

[2] Includes both chronic care and rehabilitative care.

Insured Hospital Services Within Own Province or Territory		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care:	($)					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. out-patient diagnostic care		not available	not available	not available	not available	not available
e. surgical day care (out-patient)		not available	not available	not available	not available	not available
f. other		not available	not available	not available	not available	not available
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care:	($)					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. other		not available	not available	not available	not available	not available
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care:	(#)					
a. private surgical facilities		not applicable	not applicable	not applicable	not applicable	not applicable
b. private diagnostic imaging facilities		not applicable	not applicable	not applicable	not applicable	not applicable
c. Total private for-profit health care facilities		not applicable	not applicable	not applicable	not applicable	not applicable
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care:	(#)					
a. private surgical facilities		not applicable	not applicable	not applicable	not applicable	not applicable
b. private diagnostic imaging facilities		not applicable	not applicable	not applicable	not applicable	not applicable
c. Total insured hospital services provided at private for-profit health care facilities		not applicable	not applicable	not applicable	not applicable	not applicable
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care:	($)					
a. private surgical facilities		not applicable	not applicable	not applicable	not applicable	not applicable
b. private diagnostic imaging facilities		not applicable	not applicable	not applicable	not applicable	not applicable
c. Total payments to private for-profit health care facilities		not applicable	not applicable	not applicable	not applicable	not applicable

Insured Hospital Services Provided to Residents in Another Province or Territory						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
14. Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (in Canada).	(#)	3,419	3,307	2,571	3,037	2,892
15. Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (in Canada).	(#)	28,422	28,007	21,570	29,217	26,479
16. Total payments for out-of-province/territory, in-patient, insured hospital services (in Canada).	($)	14,156,175	11,292,528	8,655,520	12,152,757	11,427,627
17. Total payments for out-of-province/territory, out-patient, insured hospital services (in Canada).	($)	2,947,701	3,451,891	2,694,973	4,089,018	3,776,489
18. Average payment for out-of-province/territory, in-patient insured hospital services (in Canada).	($)	4,140.44	3,414.73	3,366.60	4,001.57	3,951.50
19. Average payment for out-of-province/territory, out-patient insured hospital services (in Canada).	($)	103.71	123.25	124.94	139.87	142.60

Insured Hospital Services Provided Outside Canada						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
20. Total number of claims paid for out-of-country, in-patient, insured hospital services.	(#)	614	588	565	567	557
21. Total number of claims paid for out-of-country, out-patient, insured hospital services.	(#)	6,331	5,782	6,053	6,335	6,676
22. Total payments for out-of-country, in-patient, insured hospital services.	($)	991,294	1,058,815	1,028,127	1,065,302	2,008,580
23. Total payments for out-of-country, out-patient, insured hospital services.	($)	658,890	690,877	905,479	2,435,560	3,267,764
24. Average payment for out-of-country, in-patient insured hospital services.	($)	1,614.49	1,800.71	1,819.69	1,878.84	3,607.40
25. Average payment for out-of-country, out-patient insured hospital services.	($)	104.07	119.49	149.59	384.46	489.00

Insured Surgical-Dental Services Within Own Province or Territory						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
26. Number of dentists participating in the health insurance plan.	(#)	94	102	105	101	not available
27. Number of insured surgical-dental services provided by participating dentists.	(#)	2,953	2,925	3,318	3,256	3,401
28. Total payments to dentists for insured surgical-dental services.	($)	539,940	589,378	590,125	660,870	677,295
29. Average payment per service for insured surgical-dental services.	($)	182.84	201.50	177.86	202.97	199.15

Insured Physician Services Within Own Province or Territory						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
30. Number of physicians participating in the health insurance plan, by type of physician: a. general practitioners b. specialists c. other d. total	(#)	935 931 not applicable 1,866	900 938 not applicable 1,838	915 939 not applicable 1,854	948 not available not applicable not available	not available not available not applicable not available
31. Number of physicians opted-out of the health insurance plan, by type of physician: a. general practitioners b. specialists c. other d. total	(#)	not applicable not applicable not applicable not applicable	not applicable not applicable not applicable not applicable	not applicable not applicable not applicable not applicable	not applicable not applicable not applicable not applicable	not applicable not applicable not applicable not applicable
32. Number of physicians not participating in the health insurance plan, by type of physician: a. general practitioners b. specialists c. other d. total	(#)	not applicable not applicable not applicable not applicable	not applicable not applicable not applicable not applicable	not applicable not applicable not applicable not applicable	not applicable not applicable not applicable not applicable	not applicable not applicable not applicable not applicable

Insured Physician Services Within Own Province or Territory						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
33. Number of insured physician services provided, by type of physician (fee-for-service):	(#)					
a. general practitioners		5,741,645	5,859,568	5,931,022	6,211,011	6,244,197
b. specialists		7,281,386	7,698,155	8,147,749	8,741,628	9,198,787
c. other		not applicable	not applicable	not applicable	not applicable	not applicable
d. total		13,023,031	13,557,723	14,078,771	14,952,639	15,442,984
34. Number of insured physician services provided, by category of service:	(#)					
a. medical		not available	not available	not available	not available	not available *
b. surgical		not available	not available	not available	not available	not available *
c. diagnostic		not available	not available	not available	not available	not available *
d. other		not available	not available	not available	not available	not available *
e. total		not available	not available	not available	not available	not available *
35. Total payments to (fee-for-service) physicians for insured physician services, by type of physician:	($)					
a. general practitioners		99,489,900	103,068,422	114,868,502	132,200,004	140,703,474
b. specialists		153,336,002	165,946,999	178,359,474	199,231,274	214,392,377
c. other		not applicable	not applicable	not applicable	not applicable	not applicable
d. total		252,825,902	269,015,421	293,227,976	331,431,278	355,095,851
36. Total payments to physicians for insured physician services, by category of service:	($)					
a. medical		not available	not available	not available	not available	not available *
b. surgical		not available	not available	not available	not available	not available *
c. diagnostic		not available	not available	not available	not available	not available *
d. other		not available	not available	not available	not available	not available *
e. total		351,821,602	376,500,221	416,902,176	467,888,678	not available *
37. Average payment per service for insured (fee-for-service) physician services, by type of physician:	($)					
a. general practitioners		17.33	17.59	19.37	21.28	22.53
b. specialists		21.06	21.56	21.89	22.79	23.31
c. other		not applicable	not applicable	not applicable	not applicable	not applicable
d. all physicians		19.41	19.84	20.83	22.17	22.99
38. Average payment per service for insured physician services, by category of service:	($)					
a. medical		not available	not available	not available	not available	not available *
b. surgical		not available	not available	not available	not available	not available *
c. diagnostic		not available	not available	not available	not available	not available *
d. other		not available	not available	not available	not available	not available *
e. all services		not available	not available	not available	not available	not available *

* Only Fee-For-Service information is presently collected.

Insured Physician Services Provided to Residents in Another Province or Territory						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
39. Number of services paid for out-of-province/territory, insured physician services (in Canada).	(#)	217,733	206,521	183,497	192,272	211,464
40. Total payments for out-of-province/territory insured physician services (in Canada).	($)	6,245,462	6,121,559	5,568,205	6,148,444	7,381,785
41. Average payment per service for out-of-province/territory insured physician services (in Canada).	($)	28.68	29.64	30.34	31.98	34.90

Insured Physician Services Provided Outside Canada						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
42. Number of services paid for out-of-country, insured physician services.	(#)	7,222	6,587	7,116	6,763	6,345
43. Total payments for out-of-country insured physician services.	($)	518,102	519,928	520,712	500,757	529,029
44. Average payment per service for out-of-country insured physician services.	($)	71.74	78.93	73.17	74.04	83.40

Saskatchewan

Registered Persons

		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
1. Total number of persons registered under the health care insurance plan as of March 31st.	(#)	1,020,351	1,031,933	1,041,256	1,021,762	1,024,788

Insured Hospital Services Within Own Province or Territory

		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care:	(#)					
a. acute care		73	71	71	68	66
b. chronic care		0	0	0	0	0
c. rehabilitative care		1	1	1	1	1
d. out-patient diagnostic care		0	0	0	0	0
e. surgical day care (out-patient)		0	0	0	0	0
f. other		0	0	0	0	0
g. total facilities		74	72	72	69	67
3. Number of staffed beds in all facilities providing insured hospital services, by type of bed:	(#)					
a. acute care		3,117	3,078	2,944	2,802	2,544
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		142	142	142	142	142
d. out-patient diagnostic care		not applicable	not applicable	not applicable	not applicable	not applicable
e. other [1]		722	735	718	670	714
f. total staffed beds		3,981	3,955	3,804	3,614	3,400
4. Approved bed complement for all facilities providing insured hospital services, by type of bed:	(#)					
a. acute care		not applicable	not applicable	not applicable	not applicable	not applicable
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care		not applicable	not applicable	not applicable	not applicable	not applicable
e. other		not applicable	not applicable	not applicable	not applicable	not applicable
f. total approved bed complement		not applicable	not applicable	not applicable	not applicable	not applicable

[1] "Other" staffed beds include long term care beds and beds in psychiatric units of hospitals.

Insured Hospitals Services Within Own Province or Territory

		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
5. Number of separations from all facilities providing insured hospital services, by type of care:	(#)					
a. acute care		146,537	143,604	133,768	131,063	124,552 [2]
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		1,338	1,058	927	984	543 [2]
d. out-patient diagnostic care		not available	not available	not available	not available	not available
e. surgical day care (out-patient) [3]		50,090	53,890	55,426	55,526	not available
f. alternative level of care		not available	not available	not available	not available	not available
g. newborns		12,882	12,819	12,597	11,992	12,163 [2]
h. other [4]		3,988	3,309	4,065	4,646	4,647 [2]
i. total separations [5]		214,835	214,680	206,783	204,211	not available
6. Average length of in-patient stay in all facilities providing insured hospital services, by type of care:	(# of days)					
a. acute care		5.70	5.80	5.60	5.70	5.90 [2]
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		30.90	30.50	34.70	31.90	36.80 [2]
d. newborns		3.67	3.51	3.72	3.60	3.50 [2]
e. other [4]		16.50	15.40	15.80	15.40	15.00
7. Payments to facilities providing insured hospital services, by the facility's primary type of care:	($)					
a. acute care		584,582,800	565,682,800	619,538,151	680,326,248	707,505,317
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		35,115,992	35,437,299	36,824,546	38,249,010	39,654,384
d. out-patient diagnostic care		not applicable	not applicable	not applicable	not applicable	not applicable
e. surgical day care (out-patient)		not applicable	not applicable	not applicable	not applicable	not applicable
f. other		not applicable	not applicable	not applicable	not applicable	not applicable
g. total payments to facilities providing insured hospital services		619,698,792	601,120,099	656,362,697	718,575,258	747,159,701
8. Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care:	($)					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. other		not available	not available	not available	not available	not available

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[2] Separations and average length of stay for 2001-2002 are based on preliminary data.

[3] Surgical day care (out-patient) cases shown are cases involving day procedures that appear on the Canadian Institute for Health Information's 1991 list of operative procedures.

[4] "Other" separations are separations from psychiatric units in acute care hospitals.

[5] Total separations exclude long term care separations.

Insured Hospital Services Within Own Province or Territory						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care:	($)					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. out-patient diagnostic care		not available	not available	not available	not available	not available
e. surgical day care (out-patient)		not available	not available	not available	not available	not available
f. other		not available	not available	not available	not available	not available
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care:	($)					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. other		not available	not available	not available	not available	not available
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care:	(#)					
a. private surgical facilities		0	0	0	0	0
b. private diagnostic imaging facilities		0	0	0	0	0
c. Total private for-profit health care facilities		0	0	0	0	0
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care:	(#)					
a. private surgical facilities		0	0	0	0	0
b. private diagnostic imaging facilities		0	0	0	0	0
c. Total insured hospital services provided at private for-profit health care facilities		0	0	0	0	0
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care:	($)					
a. private surgical facilities		0	0	0	0	0
b. private diagnostic imaging facilities		0	0	0	0	0
c. Total payments to private for-profit health care facilities		0	0	0	0	0

Insured Hospital Services Provided to Residents in Another Province or Territory						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
14. Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (in Canada).	(#)	4,868	4,688	5,019	4,587	4,812
15. Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (in Canada).	(#)	38,279	41,375	44,327	45,195	43,944
16. Total payments for out-of-province/territory, in-patient, insured hospital services (in Canada).	($)	23,988,792	18,973,762	19,911,192	20,203,300	22,037,200
17. Total payments for out-of-province/territory, out-patient, insured hospital services (in Canada).	($)	4,161,896	3,472,464	3,504,388	6,046,600	5,836,500
18. Average payment for out-of-province/territory, in-patient insured hospital services (in Canada).	($)	4,927.85	4,047.30	3,967.16	4,404.47	4,579.63
19. Average payment for out-of-province/territory, out-patient insured hospital services (in Canada).	($)	108.73	83.93	79.06	133.79	132.82

Insured Hospital Services Provided Outside Canada						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
20. Total number of claims paid for out-of-country, in-patient, insured hospital services.	(#)	317	273	382	286	252
21. Total number of claims paid for out-of-country, out-patient, insured hospital services.	(#)	1,695	1,252	1,201	1,355	1,169
22. Total payments for out-of-country, in-patient, insured hospital services.	($)	710,626	1,193,449	2,484,961	1,022,000	1,009,400
23. Total payments for out-of-country, out-patient, insured hospital services.	($)	228,968	151,558	348,379	377,600	375,900
24. Average payment for out-of-country, in-patient insured hospital services.	($)	2,241.72	4,371.61	6,505.13	3,573.43	4,005.56
25. Average payment for out-of-country, out-patient insured hospital services.	($)	135.08	121.05	290.07	278.67	321.56

Insured Surgical-Dental Services Within Own Province or Territory					
	1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
26. Number of dentists participating in the health insurance plan. (#)	119	113	97	92	94
27. Number of insured surgical-dental services provided by participating dentists. (#)	18,700	18,500	18,100	19,900	18,900
28. Total payments to dentists for insured surgical-dental services. ($)	1,287,000	1,272,000	1,309,000	1,404,700	1,275,400
29. Average payment per service for insured surgical-dental services. ($)	68.82	68.76	72.32	70.59	67.48

Insured Physician Services Within Own Province or Territory					
	1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
30. Number of physicians participating in the health insurance plan, by type of physician: (#)					
a. general practitioners	865	907	940	1,016	937
b. specialists	592	595	610	593	696
c. other	0	0	0	0	0
d. total	1,457	1,502	1,550	1,609	1,633
31. Number of physicians opted-out of the health insurance plan, by type of physician: (#)					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0
32. Number of physicians not participating in the health insurance plan, by type of physician: (#)					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0

Insured Physician Services Within Own Province or Territory

		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
33. Number of insured physician services provided, by type of physician (fee-for-service):	(#)					
a. general practitioners		6,595,192	6,742,712	6,785,673	6,873,539	6,760,156
b. specialists		3,068,576	3,127,345	3,163,046	3,250,953	3,700,801
c. other		0	0	0	0	0
d. total		9,663,768	9,870,057	9,948,719	10,124,492	10,460,957
34. Number of insured physician services provided, by category of service: [6]	(#)					
a. medical		5,989,580 [7]	6,048,849 [7]	6,028,070 [7]	6,071,567 [7]	6,017,477 [7]
b. surgical		728,803 [8]	735,770 [8]	723,626 [8]	787,655 [8]	994,321 [8]
c. diagnostic		2,323,818 [9]	2,345,180 [9]	2,312,606 [9]	2,288,038 [9]	2,262,256 [9]
d. other		621,567 [10]	740,258 [10]	884,417 [10]	977,232 [10]	1,186,903 [10]
e. total		9,663,768	9,870,057	9,948,719	10,124,492	10,460,957
35. Total payments to (fee-for-service) physicians for insured physician services, by type of physician:	($)					
a. general practitioners		119,002,444	128,784,792	133,042,948	134,989,267	137,541,402
b. specialists		117,666,741	122,465,930	125,735,201	129,470,569	144,566,069
c. other		0	0	0	0	0
d. total		236,669,185	251,250,722	258,778,149	264,459,836	282,107,471
36. Total payments to physicians for insured physician services, by category of service: [6]	($)					
a. medical		137,691,861 [7]	143,548,623 [7]	148,848,496 [7]	151,152,270 [7]	160,742,594 [7]
b. surgical		51,536,110 [8]	51,255,592 [8]	50,843,890 [8]	51,681,286 [8]	56,027,014 [8]
c. diagnostic		37,944,132 [9]	40,473,208 [9]	41,503,336 [9]	43,216,810 [9]	44,488,404 [9]
d. other		9,497,081 [10]	15,973,299 [10]	17,582,427 [10]	18,409,471 [10]	20,849,458 [10]
e. total		236,669,184	251,250,722	258,778,149	264,459,837	282,107,470
37. Average payment per service for insured (fee-for-service) physician services, by type of physician:	($)					
a. general practitioners		18.04	19.10	19.61	19.64	20.35
b. specialists		38.35	39.16	39.75	39.83	39.06
c. other		0.00	0.00	0.00	0.00	0.00
d. all physicians		24.49	25.46	26.01	26.12	26.97
38. Average payment per service for insured physician services, by category of service:	($)					
a. medical		22.99 [7]	23.73 [7]	24.69 [7]	24.90 [7]	26.71 [7]
b. surgical		70.71 [8]	69.66 [8]	70.26 [8]	65.61 [8]	56.35 [8]
c. diagnostic		16.33 [9]	17.26 [9]	17.95 [9]	18.89 [9]	19.67 [9]
d. other		15.28 [10]	21.58 [10]	19.88 [10]	18.84 [10]	17.57 [10]
e. all services		24.49	25.46	26.01	26.12	26.97

[6] Fee-for-service.

[7] Includes visits, hospital care, psychotherapy.

[8] Includes surgeries, surgical assistance, obstetrics, anaesthesia.

[9] Includes x-rays, laboratory services, diagnostics.

[10] Includes surcharges, premiums, on-call physician services.

Insured Physician Services Provided to Residents in Another Province or Territory

		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
39. Number of services paid for out-of-province/territory, insured physician services (in Canada).	(#)	361,000	374,900	392,400	425,800	444,430
40. Total payments for out-of-province/territory insured physician services (in Canada).	($)	10,501,400	10,897,500	12,237,200	13,767,600	15,520,000
41. Average payment per service for out-of-province/territory insured physician services (in Canada).	($)	29.09	29.07	31.19	32.33	34.92

Insured Physician Services Provided Outside Canada

		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
42. Number of services paid for out-of-country, insured physician services.	(#)	not available	not available	not available	not available	not available
43. Total payments for out-of-country insured physician services.	($)	644,300	658,400	1,186,900	722,400	588,100
44. Average payment per service for out-of-country insured physician services.	($)	not available	not available	not available	not available	not available

Alberta

Registered Persons						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002 [1]
1. Total number of persons registered under the health care insurance plan as of March 31st.	(#)	2,847,538	2,912,925	2,957,045	3,007,582	3,072,384

Insured Hospital Services Within Own Province or Territory						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002 [1]
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care:	(#)					
a. acute care		102	102	102	102	103
b. chronic care		104	104	104	105	106
c. rehabilitative care		1	1	1	1	1
d. out-patient diagnostic care		not applicable	not applicable	not applicable	not applicable	not applicable
e. surgical day care (out-patient)		not applicable	not applicable	not applicable	not applicable	not applicable
f. other		0	0	3	3	3
g. total facilities		207	207	210	211	213
3. Number of staffed beds in all facilities providing insured hospital services, by type of bed:	(#)					
a. acute care		6,305	6,404	6,275	6,365 [2]	6,533
b. chronic care		6,179	6,179	6,179	6,430 [2]	6,701
c. rehabilitative care		240	240	240	240	240
d. out-patient diagnostic care		not applicable	not applicable	not applicable	not applicable	not applicable
e. other		not applicable	not applicable	not applicable	not applicable	not applicable
f. total staffed beds		12,724	12,823	12,694	13,035	13,474
4. Approved bed complement for all facilities providing insured hospital services, by type of bed:	(#)					
a. acute care		9,788	9,788	9,788	9,788	not applicable [3]
b. chronic care		6,114	6,114	6,114	6,164	not applicable [3]
c. rehabilitative care		240	240	240	240	not applicable [3]
d. out-patient diagnostic care		not applicable	not applicable	not applicable	not applicable	not applicable [3]
e. other		not applicable	not applicable	not applicable	not applicable	not applicable [3]
f. total approved bed complement		16,142	16,142	16,142	16,192	not applicable [3]

[1] These figures are considered preliminary until the release of the Alberta Ministry of Health and Wellness' *Alberta Health Care Insurance Plan Statistical Supplement, 2001-2002* .

[2] Figures were revised as per changes received by the Department of Health and Wellness from the regional health authorities.

[3] Figures are no longer provided to the Department of Health and Wellness by regional health authorities.

Insured Hospitals Services Within Own Province or Territory						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002 [1]
5. Number of separations from all facilities providing insured hospital services, by type of care:	(#)					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. out-patient diagnostic care		not available	not available	not available	not available	not available
e. surgical day care (out-patient)		not available	not available	not available	not available	not available
f. alternative level of care		not available	not available	not available	not available	not available
g. newborns		not available	not available	not available	not available	not available
h. other		not available	not available	not available	not available	not available
i. total separations		334,869	346,092	346,316	343,099	not available
6. Average length of in-patient stay in all facilities providing insured hospital services, by type of care:	(# of days)					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. newborns		not available	not available	not available	not available	not available
e. other		not available	not available	not available	not available	not available
7. Payments to facilities providing insured hospital services, by the facility's primary type of care:	($)					
a. acute care		not applicable	not applicable	not applicable	not applicable	not applicable
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care		not applicable	not applicable	not applicable	not applicable	not applicable
e. surgical day care (out-patient)		not applicable	not applicable	not applicable	not applicable	not applicable
f. other		not applicable	not applicable	not applicable	not applicable	not applicable
g. total payments to facilities providing insured hospital services		not applicable	not applicable	not applicable	not applicable	not applicable
8. Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care:	($)					
a. acute care		not applicable	not applicable	not applicable	not applicable	not applicable
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. other		not applicable	not applicable	not applicable	not applicable	not applicable

[1] These figures are considered preliminary until the release of the Alberta Ministry of Health and Wellness' *Alberta Health Care Insurance Plan Statistical Supplement, 2001-2002* .

Insured Hospital Services Within Own Province or Territory						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002 [1]
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care:	($)					
a. acute care		not applicable	not applicable	not applicable	not applicable	not applicable
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care		not applicable	not applicable	not applicable	not applicable	not applicable
e. surgical day care (out-patient)		not applicable	not applicable	not applicable	not applicable	not applicable
f. other		not applicable	not applicable	not applicable	not applicable	not applicable
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care:	($)					
a. acute care		not applicable	not applicable	not applicable	not applicable	not applicable
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. other		not applicable	not applicable	not applicable	not applicable	not applicable
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care:	(#)					
a. private surgical facilities		not available	not available	not available	not available	not available
b. private diagnostic imaging facilities		not available	not available	not available	not available	not available
c. Total private for-profit health care facilities		not available	not available	not available	not available	not available
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care:	(#)					
a. private surgical facilities		not available	not available	not available	not available	not available
b. private diagnostic imaging facilities		not available	not available	not available	not available	not available
c. Total insured hospital services provided at private for-profit health care facilities		not available	not available	not available	not available	not available
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care:	($)					
a. private surgical facilities		not available	not available	not available	not available	not available
b. private diagnostic imaging facilities		not available	not available	not available	not available	not available
c. Total payments to private for-profit health care facilities		not available	not available	not available	not available	not available

[1] These figures are considered preliminary until the release of the Alberta Ministry of Health and Wellness' *Alberta Health Care Insurance Plan Statistical Supplement, 2001-2002*.

Insured Hospital Services Provided to Residents in Another Province or Territory						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002[1]
14. Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (in Canada).	(#)	4,656	4,714	4,820	4,656	4,205
15. Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (in Canada).	(#)	56,408	57,574	58,443	56,408	61,230
16. Total payments for out-of-province/territory, in-patient, insured hospital services (in Canada).	($)	14,699,049	13,269,781	13,632,730	14,699,049	12,328,205
17. Total payments for out-of-province/territory, out-patient, insured hospital services (in Canada).	($)	5,287,271	6,706,065	6,920,702	5,287,271	7,115,105
18. Average payment for out-of-province/territory, in-patient insured hospital services (in Canada).	($)	3,157.01	2,814.97	2,828.37	3,157.01	2,931.80
19. Average payment for out-of-province/territory, out-patient insured hospital services (in Canada).	($)	93.73	116.48	118.42	93.73	116.20

Insured Hospital Services Provided Outside Canada						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002[1]
20. Total number of claims paid for out-of-country, in-patient, insured hospital services.	(#)	3,843	4,005	5,215	4,151	4,457
21. Total number of claims paid for out-of-country, out-patient, insured hospital services.	(#)	4,668	3,777	5,087	3,945	3,942
22. Total payments for out-of-country, in-patient, insured hospital services.	($)	363,087	356,747	483,648	374,005	416,635
23. Total payments for out-of-country, out-patient, insured hospital services.	($)	349,217	275,687	364,087	298,725	309,119
24. Average payment for out-of-country, in-patient insured hospital services.	($)	94.48	89.08	92.74	90.10	93.48
25. Average payment for out-of-country, out-patient insured hospital services.	($)	74.81	72.99	71.43	75.72	78.42

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[1] These figures are considered preliminary until the release of the Alberta Ministry of Health and Wellness' *Alberta Health Care Insurance Plan Statistical Supplement, 2001-2002*.

Insured Surgical-Dental Services Within Own Province or Territory						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002 [1]
26. Number of dentists participating in the health insurance plan.	(#)	230	232	250	232	250
27. Number of insured surgical-dental services provided by participating dentists.	(#)	10,648	11,920	14,292	14,708	14,585
28. Total payments to dentists for insured surgical-dental services.	($)	1,691,797	1,853,322	2,092,063	2,116,386	2,167,896
29. Average payment per service for insured surgical-dental services.	($)	158.88	155.48	146.38	143.89	148.64

Insured Physician Services Within Own Province or Territory						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002 [1]
30. Number of physicians participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners		2,365	2,464	2,545	2,659	2,746
b. specialists		1,903	1,978	2,096	2,197	2,333
c. other		not applicable	not applicable	not applicable	not applicable	not applicable
d. total		4,268	4,442	4,641	4,856	5,079
31. Number of physicians opted-out of the health insurance plan, by type of physician:	(#)					
a. general practitioners		not applicable	not applicable	not applicable	not applicable	not applicable
b. specialists		not applicable	not applicable	not applicable	not applicable	not applicable
c. other		not applicable	not applicable	not applicable	not applicable	not applicable
d. total		not applicable	not applicable	not applicable	not applicable	not applicable
32. Number of physicians not participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners		0	0	0	0	0
b. specialists		0	0	0	1	0
c. other		0	0	0	0	0
d. total		0	0	0	1	0

[1] These figures are considered preliminary until the release of the Alberta Ministry of Health and Wellness' *Alberta Health Care Insurance Plan Statistical Supplement, 2001-2002*.

Insured Physician Services Within Own Province or Territory					
	1997-1998	1998-1999	1999-2000	2000-2001	2001-2002 [1]
33. Number of insured physician services provided, by type of physician (fee-for-service): (#)					
a. general practitioners	14,377,354	14,974,783	15,543,092	15,914,666	16,132,591
b. specialists	9,844,887	10,392,632	10,798,883	11,319,078	11,710,080
c. other	0	0	0	0	0
d. total	24,222,241	25,367,415	26,341,975	27,233,744	27,842,671
34. Number of insured physician services provided, by category of service: (#)					
a. medical	18,411,601	19,119,550	19,829,029	20,328,498	20,647,611
b. surgical	1,155,663	1,211,712	1,238,043	1,316,312	1,396,422
c. diagnostic	4,654,977	5,036,153	5,274,903	5,588,934	5,798,638
d. other	0	0	0	0	0
e. total	24,222,241	25,367,415	26,341,975	27,233,744	27,842,671
35. Total payments to (fee-for-service) physicians for insured physician services, by type of physician: ($)					
a. general practitioners	357,611,870	383,842,634	410,502,506	430,681,658	474,076,958
b. specialists	427,232,284	464,270,463	493,040,446	528,392,197	587,092,735
c. other	0	0	0	0	0
d. total	784,844,154	848,113,097	903,542,952	959,073,855	1,061,169,693
36. Total payments to physicians for insured physician services, by category of service: ($)					
a. medical	514,667,078	549,507,274	586,587,852	618,596,110	684,971,654
b. surgical	125,595,149	133,916,239	140,087,988	150,223,933	164,427,152
c. diagnostic	144,581,927	164,689,584	176,867,112	190,253,812	211,770,887
d. other	0	0	0	0	0
e. total	784,844,154	848,113,097	903,542,952	959,073,855	1,061,169,693
37. Average payment per service for insured (fee-for-service) physician services, by type of physician: ($)					
a. general practitioners	24.87	25.63	26.41	27.06	29.39
b. specialists	43.40	44.67	45.66	46.68	50.14
c. other	0.00	0.00	0.00	0.00	0.00
d. all physicians	32.40	33.43	34.30	35.22	38.11
38. Average payment per service for insured physician services, by category of service: ($)					
a. medical	27.95	28.74	29.58	30.43	33.17
b. surgical	108.68	110.52	113.14	114.12	117.75
c. diagnostic	31.06	32.70	33.53	34.04	36.52
d. other	0.00	0.00	0.00	0.00	0.00
e. all services	32.40	33.43	34.30	35.22	38.11

[1] These figures are considered preliminary until the release of the Alberta Ministry of Health and Wellness' *Alberta Health Care Insurance Plan Statistical Supplement, 2001-2002*.

Insured Physician Services Provided to Residents in Another Province or Territory

		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002 [1]
39. Number of services paid for out-of-province/territory, insured physician services (in Canada).	(#)	348,480	359,653	380,635	418,587	493,798
40. Total payments for out-of-province/territory insured physician services (in Canada).	($)	10,092,203	9,983,110	11,397,620	12,436,188	11,998,825
41. Average payment per service for out-of-province/territory insured physician services (in Canada).	($)	28.96	27.76	29.94	29.71	24.30

Insured Physician Services Provided Outside Canada

		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002 [1]
42. Number of services paid for out-of-country, insured physician services.	(#)	30,649	25,192	21,989	20,891	22,928
43. Total payments for out-of-country insured physician services.	($)	972,645	862,852	871,292	907,010	1,043,997
44. Average payment per service for out-of-country insured physician services.	($)	31.73	34.25	39.62	43.42	45.53

[1] These figures are considered preliminary until the release of the Alberta Ministry of Health and Wellness' *Alberta Health Care Insurance Plan Statistical Supplement, 2001-2002*.

British Columbia

Registered Persons					
	1997-1998	**1998-1999**	**1999-2000**	**2000-2001**	**2001-2002**
1. Total number of persons registered under the health care insurance plan as of March 31st. **(#)**	3,951,853	3,924,490	3,943,991	4,022,789	4,076,892

Insured Hospital Services Within Own Province or Territory					
	1997-1998	**1998-1999**	**1999-2000**	**2000-2001**	**2001-2002**
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care: **(#)**					
a. acute care	93	94	94	94	94
b. chronic care	17	17	17	18	18
c. rehabilitative care	3	3	3	3	3
d. out-patient diagnostic care	25	25	25	25	25
e. surgical day care (out-patient)	not applicable	not applicable	not applicable	not applicable	not applicable
f. other	1	0	0	0	0
g. total facilities	139	139	139	140	140
3. Number of staffed beds in all facilities providing insured hospital services, by type of bed: **(#)**					
a. acute care	not available	not available	not available	not available	not available
b. chronic care	not available	not available	not available	not available	not available
c. rehabilitative care	not available	not available	not available	not available	not available
d. out-patient diagnostic care	not available	not available	not available	not available	not available
e. other	not available	not available	not available	not available	not available
f. total staffed beds	not available	not available	not available	not available	not available
4. Approved bed complement for all facilities providing insured hospital services, by type of bed: **(#)**					
a. acute care	8,822	8,834	8,533	8,994	9,318
b. chronic care [1]	7,269	7,364	7,247	7,261	7,334
c. rehabilitative care	242	242	468	474	475
d. out-patient diagnostic care	not applicable	not applicable	not applicable	not applicable	not applicable
e. other	not applicable	not applicable	not applicable	not applicable	not applicable
f. total approved bed complement	16,333	16,440	16,248	16,729	17,127

Data for measures 1 through 4 for 2001-2002 are preliminary.

Data for measures 1 through 4 have been restated for all years to reflect changes in data sources, definitions and methodology.

[1] Data has been restated to reflect methodological changes. Data are calculated as the sum of total days of care provided in each facility in the year / 365 days in a year.

Insured Hospitals Services Within Own Province or Territory

		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
5. Number of separations from all facilities providing insured hospital services, by type of care:	(#)					
a. acute care [2]		404,926	392,319	391,817	378,822	353,117
b. chronic care [3]		4,780	4,608	4,884	4,700	4,890
c. rehabilitative care [2 4]		1,231	1,256	1,261	1,421	1,495
d. out-patient diagnostic care		not available	not available	not available	not available	not available
e. surgical day care (out-patient)		264,043	258,648	284,895	289,900	293,346
f. alternative level of care		not applicable	not applicable	not applicable	not applicable	not applicable
g. newborns		43,924	42,169	41,698	40,204	39,669
h. other [5]		2,019	2,287	not applicable	not applicable	not applicable
i. total separations		720,923	701,287	724,555	715,047	692,517
6. Average length of in-patient stay in all facilities providing insured hospital services, by type of care: [6]	(# of days)					
a. acute care [7]		6.40	6.60	6.90	7.10	7.20
b. chronic care		648.00	604.00	598.00	586.00	618.00
c. rehabilitative care [4]		48.45	46.47	45.00	41.50	39.76
d. newborns		2.81	2.75	2.70	3.00	3.02
e. other [7]		60.70	57.70	not applicable	not applicable	not applicable
7. Payments to facilities providing insured hospital services, by the facility's primary type of care: [8]	($)					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. out-patient diagnostic care		not available	not available	not available	not available	not available
e. surgical day care (out-patient)		not available	not available	not available	not available	not available
f. other		not available	not available	not available	not available	not available
g. total payments to facilities providing insured hospital services		not available	not available	not available	not available	not available
8. Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care:	($)					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. other		not available	not available	not available	not available	not available

Data for measures 5 through 8 for 2001-2002 are preliminary.

Data for measures 5 through 8 have been restated for all years to reflect changes in data sources, definitions and methodology.

[2] Includes newborns, stillbirths and residents from other provinces and territories. N.B. non-residents includes out of country throughout.

[3] Data has been restated to reflect methodological changes. Data reported from the Discharge Abstract Database (DAD) has been replaced with information from the Continuing Care Data Warehouse for extended facilities that formally reported through DAD.

[4] Data has been restated to reflect methodological changes that were made by the Canadian Institute for Health Information (CIHI).

[5] As of 1999-2000, separations formerly counted under the "other" category have been reclassified as Alternative Level of Care and captured under the acute care category (measure 5a).

[6] The number of days a patient stays in a health care facility are assigned to a year based on the date the patient separates from the health care facility. Therefore, length of stay may include days a patient stayed in a health care facility during the previous year.

[7] For years 1997-1998 and 1998-1999, discharge planning unit separations are captured under the other category. From 1999-2000 onward, discharge planning unit separations are classified as Alternative Level of Care and captured under the acute care category.

[8] Payments are made by the Ministry of Health Services to Health Authorities for the provision of a full range of regionally delivered services, including insured hospital services. In 1999-2000 these payments totalled $4.4 billion; in 2000-2001, $5.1 billion, and in 2001-2002, $5.4 billion.

Insured Hospital Services Within Own Province or Territory	1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care: ($)					
a. acute care	not available	not available	not available	not available	not available
b. chronic care	not available	not available	not available	not available	not available
c. rehabilitative care	not available	not available	not available	not available	not available
d. out-patient diagnostic care	not available	not available	not available	not available	not available
e. surgical day care (out-patient)	not available	not available	not available	not available	not available
f. other	not available	not available	not available	not available	not available
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care: ($)					
a. acute care	not available	not available	not available	not available	not available
b. chronic care	not available	not available	not available	not available	not available
c. rehabilitative care	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care: [9] (#)					
a. private surgical facilities	not available	not available	1	1	1
b. private diagnostic imaging facilities	not available	not available	not available	not available	not available
c. Total private for-profit health care facilities	not available	not available	1	1	1
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care: [9] (#)					
a. private surgical facilities	not available	not available	810	634	689
b. private diagnostic imaging facilities	not available	not available	not available	not available	not available
c. Total insured hospital services provided at private for-profit health care facilities	not available	not available	810	634	689
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care: [9] ($)					
a. private surgical facilities	not available	not available	558,000	348,700	353,100
b. private diagnostic imaging facilities	not available	not available	not available	not available	not available
c. Total payments to private for-profit health care facilities	not available	not available	558,000	348,700	353,100

Data for measures 9 and 10 for 2001-2002 are preliminary.

Data for measures 9 and 10 have been restated for all years to reflect changes in data sources, definitions and methodology.

[9] There are approximately 50 private facilities licensed by the College of Physicians and Surgeons of British Columbia. These facilities provide mostly non-Canada Health Act services. Under the *Medicare Protection Act* , they are prohibited from extra-billing for any insured services.

Insured Hospital Services Provided to Residents in Another Province or Territory		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
14. Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (in Canada).	(#)	7,383	7,994	7,231	8,113	8,113
15. Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (in Canada).	(#)	68,146	73,807	70,070	83,765	80,732
16. Total payments for out-of-province/territory, in-patient, insured hospital services (in Canada).	($)	35,898,630	35,830,522	34,477,406	35,882,521	40,898,996
17. Total payments for out-of-province/territory, out-patient, insured hospital services (in Canada).	($)	7,441,321	9,075,191	9,585,916	9,149,496	10,604,141
18. Average payment for out-of-province/territory, in-patient insured hospital services (in Canada).	($)	4,862.00	4,482.00	4,768.00	4,422.84	5,041.17
19. Average payment for out-of-province/territory, out-patient insured hospital services (in Canada).	($)	109.00	123.00	137.00	109.23	131.35

Insured Hospital Services Provided Outside Canada		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
20. Total number of claims paid for out-of-country, in-patient, insured hospital services.	(#)	2,888	2,793	2,494	2,097	1,964
21. Total number of claims paid for out-of-country, out-patient, insured hospital services.	(#)	431	435	324	720	637
22. Total payments for out-of-country, in-patient, insured hospital services.	($)	3,073,456	3,492,437	5,375,289	6,463,676	9,246,228
23. Total payments for out-of-country, out-patient, insured hospital services.	($)	109,347	100,863	65,137	134,789	119,928
24. Average payment for out-of-country, in-patient insured hospital services.	($)	1,064.00	1,250.00	2,155.00	3,082.34	4,707.86
25. Average payment for out-of-country, out-patient insured hospital services.	($)	254.00	232.00	201.00	187.21	188.27

Insured Surgical-Dental Services Within Own Province or Territory						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
26. Number of dentists participating in the health insurance plan.	(#)	289	280	265	283	275
27. Number of insured surgical-dental services provided by participating dentists.	(#)	53,163	51,096	54,507	55,820	43,635
28. Total payments to dentists for insured surgical-dental services.	($)	5,818,127	5,474,563	5,854,368	5,718,859	4,206,983
29. Average payment per service for insured surgical-dental services.	($)	109.43	107.14	107.40	102.00	96.41

Insured Physician Services Within Own Province or Territory						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
30. Number of physicians participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners		4,248	4,269	4,276	4,360	4,430
b. specialists		3,181	3,232	3,269	3,298	3,380
c. other		0	0	0	0	0
d. total		7,429	7,501	7,545	7,658	7,810
31. Number of physicians opted-out of the health insurance plan, by type of physician:	(#)					
a. general practitioners		3	4	4	3	3
b. specialists		11	13	10	5	3
c. other		0	0	0	0	0
d. total		14	17	14	8	6
32. Number of physicians not participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners		1	1	1	1	1
b. specialists		0	0	0	0	0
c. other		0	0	0	0	0
d. total		1	1	1	1	1

Insured Physician Services Within Own Province or Territory						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
33. Number of insured physician services provided, by type of physician (fee-for-service):	(#)					
a. general practitioners		22,378,959	21,903,525	22,875,620	23,051,810	22,800,417
b. specialists		29,424,394	29,860,276	32,697,836	34,551,897	36,193,233
c. other		not applicable	not applicable	not applicable	not applicable	not applicable
d. total		51,803,353	51,763,801	55,573,456	57,603,707	58,993,650
34. Number of insured physician services provided, by category of service:	(#)					
a. medical		24,309,601	24,012,366	25,065,926	25,201,483	24,994,070
b. surgical		4,209,195	4,163,434	4,426,656	4,417,069	4,317,461
c. diagnostic		23,294,557	23,588,001	26,080,874	27,985,155	29,682,119
d. other		not applicable	not applicable	not applicable	not applicable	not applicable
e. total		51,813,353	51,763,801	55,573,456	57,603,707	58,993,650
35. Total payments to (fee-for-service) physicians for insured physician services, by type of physician:	($)					
a. general practitioners		614,713,789	626,992,277	654,305,224	663,325,757	716,885,396
b. specialists		831,174,498	845,235,143	928,642,083	965,611,051	1,072,360,970
c. other		not applicable	not applicable	not applicable	not applicable	not applicable
d. total		1,445,888,287	1,472,227,420	1,582,947,307	1,628,936,808	1,789,246,366
36. Total payments to physicians for insured physician services, by category of service:	($)					
a. medical		850,453,217	874,004,742	920,552,743	936,095,517	1,018,076,225
b. surgical		231,507,497	229,196,329	250,267,000	252,827,989	279,673,918
c. diagnostic		363,927,573	369,026,348	412,127,564	440,013,302	491,496,223
d. other		not applicable	not applicable	not applicable	not applicable	not applicable
e. total		1,445,888,287	1,472,227,419	1,582,947,307	1,628,936,808	1,789,246,366
37. Average payment per service for insured (fee-for-service) physician services, by type of physician:	($)					
a. general practitioners		27.40	28.60	28.60	27.78	31.44
b. specialists		28.20	28.30	28.40	27.95	29.63
c. other		not applicable	not applicable	not applicable	not applicable	not applicable
d. all physicians		27.90	28.44	28.48	28.28	30.33
38. Average payment per service for insured physician services, by category of service:	($)					
a. medical		34.98	36.40	36.72	37.14	40.73
b. surgical		55.00	55.04	56.53	57.24	64.78
c. diagnostic		15.62	15.64	15.80	15.74	16.56
d. other		not applicable	not applicable	not applicable	not applicable	not applicable
e. all services		27.90	28.44	28.48	28.28	30.33

Insured Physician Services Provided to Residents in Another Province or Territory						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
39. Number of services paid for out-of-province/territory, insured physician services (in Canada).	(#)	461,571	438,186	446,232	456,266	461,154
40. Total payments for out-of-province/territory insured physician services (in Canada).	($)	13,849,906	13,495,893	14,134,689	14,380,195	14,915,996
41. Average payment per service for out-of-province/territory insured physician services (in Canada).	($)	30.01	30.80	31.68	31.52	32.34

Insured Physician Services Provided Outside Canada						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
42. Number of services paid for out-of-country, insured physician services.	(#)	not available	73,297	66,361	68,707	69,455
43. Total payments for out-of-country insured physician services.	($)	not available	3,504,870	3,336,415	3,947,293	4,381,495
44. Average payment per service for out-of-country insured physician services.	($)	not available	47.82	50.28	57.45	63.08

Yukon

Registered Persons					
	1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
1. Total number of persons registered under the health care insurance plan as of March 31st. (#)	33,557	31,925	31,255	31,133	31,036

Insured Hospital Services Within Own Province or Territory					
	1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care: (#)					
a. acute care	2	2	2	2	2
b. chronic care	0	0	0	0	0
c. rehabilitative care	0	0	0	0	0
d. out-patient diagnostic care	0	0	0	0	0
e. surgical day care (out-patient)	0	0	0	0	0
f. other	13[1]	13[1]	13[1]	13[1]	13[1]
g. total facilities	15	15	15	15	15
3. Number of staffed beds in all facilities providing insured hospital services, by type of bed: (#)					
a. acute care	59	59	61	61	61
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care	not applicable	not applicable	not applicable	not applicable	not applicable
e. other	9[2]	9[2]	9[2]	9[2]	9[2]
f. total staffed beds	68	68	70	70	70
4. Approved bed complement for all facilities providing insured hospital services, by type of bed: (#)					
a. acute care	59	59	61	61	61
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care	not applicable	not applicable	not applicable	not applicable	not applicable
e. other	9[2]	9[2]	9[2]	9[2]	9[2]
f. total approved bed complement	68	68	70	70	70

[1] Includes health centres and one health station.

[2] Day surgery beds.

Insured Hospitals Services Within Own Province or Territory						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
5. Number of separations from all facilities providing insured hospital services, by type of care:	(#)					
a. acute care		3,283	3,117	2,967	3,021	2,986
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care		not applicable	not applicable	not applicable	not applicable	not applicable
e. surgical day care (out-patient)		1,524	1,606	1,624	1,619	1,542
f. alternative level of care		0	0	0	0	0
g. newborns		437	392	374	363	340
h. other		0 [1]	0 [1]	0 [1]	0 [1]	0 [1]
i. total separations		5,244	5,115	4,965	5,003	4,868
6. Average length of in-patient stay in all facilities providing insured hospital services, by type of care:	(# of days)					
a. acute care		4.00	4.50	4.70	4.70	4.70
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. newborns		3.00	2.90	3.00	3.10	3.00
e. other		not available [1]	not available [1]	not available [1]	not available [1]	not applicable [1]
7. Payments to facilities providing insured hospital services, by the facility's primary type of care:	($)					
a. acute care		18,836,846	19,023,617	19,587,158	20,350,026	21,920,937
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care		not applicable	not applicable	not applicable	not applicable	not applicable
e. surgical day care (out-patient)		0	0	0	0	0
f. other		4,722,168 [1]	4,796,107 [1]	5,502,144 [1]	5,483,948 [1]	5,997,920 [1]
g. total payments to facilities providing insured hospital services		23,559,014	23,819,724	25,089,302	25,833,974	27,918,857
8. Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care:	($)					
a. acute care		505.00	694.50	694.50	694.50	694.50
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. other		not available	not available	not available	not available	not applicable

[1] Includes health centres and one health station.

Insured Hospital Services Within Own Province or Territory						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care:	($)					
a. acute care		89.00	110.00	110.00	110.00	110.00
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care		not applicable	not applicable	not applicable	not applicable	not applicable
e. surgical day care (out-patient)		292.00	400.00	400.00	400.00	400.00
f. other		not applicable	not applicable	not applicable	not applicable	not applicable
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care:	($)					
a. acute care		362.68	349.71	337.15	335.46	396.23
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. other		not applicable	not applicable	not applicable	not applicable	not applicable
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care:	(#)					
a. private surgical facilities		0	0	0	0	0
b. private diagnostic imaging facilities		0	0	0	0	0
c. Total private for-profit health care facilities		0	0	0	0	0
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care:	(#)					
a. private surgical facilities		0	0	0	0	0
b. private diagnostic imaging facilities		0	0	0	0	0
c. Total insured hospital services provided at private for-profit health care facilities		0	0	0	0	0
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care:	($)					
a. private surgical facilities		0	0	0	0	0
b. private diagnostic imaging facilities		0	0	0	0	0
c. Total payments to private for-profit health care facilities		0	0	0	0	0

Insured Hospital Services Provided to Residents in Another Province or Territory						
		1997-1998	1998-1999	1999-2000	2000-2001[1]	2001-2002[1]
14. Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (in Canada).	(#)	732	769	735	719	724
15. Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (in Canada).	(#)	6,109	6,637	7,025	6,760	7,188
16. Total payments for out-of-province/territory, in-patient, insured hospital services (in Canada).	($)	4,434,174	4,196,661	4,683,562	4,218,846	4,263,271
17. Total payments for out-of-province/territory, out-patient, insured hospital services (in Canada).	($)	645,165	826,425	920,768	861,375	938,871
18. Average payment for out-of-province/territory, in-patient insured hospital services (in Canada).	($)	6,057.62	5,457.30	6,372.20	5,867.66	5,888.50
19. Average payment for out-of-province/territory, out-patient insured hospital services (in Canada).	($)	105.61	124.52	131.07	127.43	130.62

Insured Hospital Services Provided Outside Canada						
		1997-1998	1998-1999	1999-2000	2000-2001[1]	2001-2002[1]
20. Total number of claims paid for out-of-country, in-patient, insured hospital services.	(#)	14	13	11	9	14
21. Total number of claims paid for out-of-country, out-patient, insured hospital services.	(#)	42	53	67	54	39
22. Total payments for out-of-country, in-patient, insured hospital services.	($)	34,445	45,440	22,125	27,520	48,621
23. Total payments for out-of-country, out-patient, insured hospital services.	($)	5,502	7,354	7,080	8,368	4,321
24. Average payment for out-of-country, in-patient insured hospital services.	($)	2,460.36	3,495.38	2,011.37	3,057.78	3,472.93
25. Average payment for out-of-country, out-patient insured hospital services.	($)	131.00	138.76	105.68	154.97	110.80

[1] Data are as of November 2002

Insured Surgical-Dental Services Within Own Province or Territory		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
26. Number of dentists participating in the health insurance plan.	(#)	10	12	9	11	11
27. Number of insured surgical-dental services provided by participating dentists.	(#)	203	297	214	222	214
28. Total payments to dentists for insured surgical-dental services.	($)	50,840	64,387	59,458	50,876	51,078
29. Average payment per service for insured surgical-dental services.	($)	250.44	217.19	277.84	229.17	238.69

Insured Physician Services Within Own Province or Territory		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
30. Number of physicians participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners		52	40	41	43	49
b. specialists		4	4	5	6	5
c. other		0	0	0	0	0
d. total		56	44	46	49	54
31. Number of physicians opted-out of the health insurance plan, by type of physician:	(#)					
a. general practitioners		0	0	0	0	0
b. specialists		0	0	0	0	0
c. other		0	0	0	0	0
d. total		0	0	0	0	0
32. Number of physicians not participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners		0	0	0	0	0
b. specialists		0	0	0	0	0
c. other		0	0	0	0	0
d. total		0	0	0	0	0

Insured Physician Services Within Own Province or Territory					
	1997-1998	**1998-1999**	**1999-2000**	**2000-2001**	**2001-2002**
33. Number of insured physician services provided, by type of physician (fee-for-service) **(#)**					
a. general practitioners	164,544	151,743	153,542	164,497	160,932
b. specialists	10,885	14,170	11,704	14,789	11,881
c. other	0	0	0	0	0
d. total	175,429	165,913	165,246	179,286	172,813
34. Number of insured physician services provided, by category of service **(#)**					
a. medical	127,479	120,830	123,333	131,685	131,004
b. surgical	25,425	23,110	22,092	25,670	26,653
c. diagnostic	22,525	21,972	19,822	18,978	15,156
d. other	0	0	0	0	0
e. total	175,429	165,912	165,247	176,333	172,813
35. Total payments to (fee-for-service) physicians for insured physician services, by type of physician: **($)**					
a. general practitioners	5,335,775	5,058,606	5,248,704	5,803,619	5,692,583
b. specialists	1,184,312	1,321,577	1,189,271	1,263,380	1,143,968
c. other	0	0	0	0	0
d. total	6,520,087	6,380,183	6,437,975	7,066,999	6,836,551
36. Total payments to physicians for insured physician services, by category of service: **($)**					
a. medical	5,182,278	5,026,530	5,144,453	5,729,729	5,550,975
b. surgical	995,148	1,005,170	978,628	1,028,529	1,057,467
c. diagnostic	342,661	348,483	314,893	308,741	228,109
d. other	0	0	0	0	0
e. total	6,520,087	6,380,183	6,437,974	7,066,999	6,836,551
37. Average payment per service for insured (fee-for-service) physician services, by type of physician: **($)**					
a. general practitioners	32.43	33.34	34.18	35.28	35.38
b. specialists	108.80	93.27	101.61	85.43	96.29
c. other	0.00	0.00	0.00	0.00	0.00
d. all physicians	37.17	38.45	38.96	39.42	39.56
38. Average payment per service for insured physician services, by category of service: **($)**					
a. medical	40.65	41.60	41.71	43.51	42.38
b. surgical	39.14	43.50	44.30	40.07	39.68
c. diagnostic	15.21	15.86	15.89	16.27	15.05
d. other	0.00	0.00	0.00	0.00	0.00
e. all services	37.17	38.46	38.96	40.08	39.56

Insured Physician Services Provided to Residents in Another Province or Territory[4]						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
39. Number of services paid for out-of-province/territory, insured physician services (in Canada).	(#)	28,656	29,834	31,020	36,828	32,461
40. Total payments for out-of-province/territory insured physician services (in Canada).	($)	1,183,519	1,207,371	1,404,195	1,642,495	1,601,642
41. Average payment per service for out-of-province/territory insured physician services (in Canada).	($)	41.30	40.47	45.27	44.60	49.34

Insured Physician Services Provided Outside Canada						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
42. Number of services paid for out-of-country, insured physician services.	(#)	not available	not available	not available	not available	not available
43. Total payments for out-of-country insured physician services.	($)	not available	not available	not available	not available	not available
44. Average payment per service for out-of-country insured physician services.	($)	not available	not available	not available	not available	not available

[4] Includes out-of-country physician services.

Insured Physician Services Within Own Province or Territory, Visiting Specialists, Locum Doctors and Member Reimbursements [3]

		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
45. Number of physicians participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners		not available	not available	not available	not available	not available
b. specialists		not available	not available	not available	not available	not available
c. all physicians		not available	not available	not available	not available	not available
46. Number of insured services provided, by category of physicians (fee-for-service):	(#)					
a. general practitioners		27,583	30,391	27,757	32,986	18,663
b. specialists		11,848	10,443	11,332	7,009	11,323
c. all physicians		39,431	40,834	39,089	39,995	29,986
47. Number of insured services provided, by category services	(#)					
a. medical services		33,975	33,007	31,609	31,099	23,431
b. surgical services		1,842	4,483	5,141	6,121	4,888
c. diagnostic services		3,614	3,344	2,339	2,775	1,667
d. all insured physician services		39,431	40,834	39,069	39,995	29,986
48. Total payment of (fee-for-service) physicians for insured services by category of physicians:	(#)					
a. general practitioners		983,271	994,636	907,848	1,156,197	699,718
b. specialists		756,719	681,869	727,972	303,424	885,944
c. all physicians		1,739,990	1,676,505	1,635,820	1,459,621	1,585,662
49. Total payment to physicians for insured services, by category of	(#)					
a. medical services		1,542,518	1,477,892	1,436,115	1,133,717	1,224,899
b. surgical services		112,736	121,755	132,349	260,188	285,503
c. diagnostic services		84,736	76,857	67,356	65,716	75,261
d. all insured physician services		1,739,990	1,676,504	1,635,820	1,459,621	1,585,663
50. Average payment for insured (fee-for-service) physicians services by category of physicians:	($)					
a. general practitioners		35.65	32.73	32.71	35.05	37.50
b. specialists		63.87	65.29	64.24	43.29	78.25
c. all physicians		44.13	41.06	41.85	36.50	52.88
51. Average payment for insured physician services by category of	($)					
a. medical services		45.40	44.78	45.43	36.46	52.28
b. surgical services		61.20	27.16	25.74	42.51	58.41
c. diagnostic services		23.45	22.98	28.80	23.68	45.15
d. all insured physician services		44.13	41.06	41.85	36.50	52.88

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[3] Data are as of November 2002.

Northwest Territories

Registered Persons		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
1. Total number of persons registered under the health care insurance plan as of March 31st.	(#)			41,000	41,673	42,885[1]

Insured Hospital Services Within Own Province or Territory		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care:	(#)					
a. acute care				4 hospitals	4 hospitals	4 hospitals
b. chronic care				not available[2]	not available[2]	not available[2]
c. rehabilitative care				not available[2]	not available[2]	not available[2]
d. out-patient diagnostic care				not available[2]	not available[2]	not available[2]
e. surgical day care (out-patient)				not available[2]	not available[2]	not available[2]
f. other				28[3]	28[3]	28[3]
g. total facilities				32	32	32
3. Number of staffed beds in all facilities providing insured hospital services, by type of bed:	(#)					
a. acute care				not available	not available	not available
b. chronic care				not available	not available	not available
c. rehabilitative care				not available	not available	not available
d. out-patient diagnostic care				not available	not available	not available
e. other				not available	not available	not available
f. total staffed beds				212	220	173
4. Approved bed complement for all facilities providing insured hospital services, by type of bed:	(#)					
a. acute care				not available	not available	not available
b. chronic care				not available	not available	not available
c. rehabilitative care				not available	not available	not available
d. out-patient diagnostic care				not available	not available	not available
e. other				not available	not available	not available
f. total approved bed complement				212	220	173

[1] As of September 19, 2002

[2] Northwest Territories does not have facilities that provide these services as their primary type of care. Instead, the 4 hospital acute care facilities provide long term care, extended care, day surgery, out-patient services, diagnostic services and rehabilitative care.

[3] Includes Health Centres and Public Health Units. Figures for measures 3 through 25 do not include Health Centre and Public Health Unit activity.

Statistics for 1997-1998 and 1998-1999 are not provided as effective April 1, 1999, Nunavut Territory was formed from part of the Northwest Territories.

Insured Hospitals Services Within Own Province or Territory	1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
5. Number of separations from all facilities providing insured hospital services, by type of care: (#)					
a. acute care			not available	not available	not available
b. chronic care			not available	not available	not available
c. rehabilitative care			7,955	7,216	6,947
d. out-patient diagnostic care			not available	not available	not available
e. surgical day care (out-patient)			2,773	2,445	1,922
f. alternative level of care			not available	not available	not available
g. newborns			474	727	454
h. other			59,641	65,401	67,016
i. total separations			70,843	75,789	76,339
6. Average length of in-patient stay in all facilities providing insured hospital services, by type of care: (# of days)					
a. acute care			not available	not available	not available
b. chronic care			not available	not available	not available
c. rehabilitative care			15.20	11.10	6.40
d. newborns			2.88	2.97	2.90
e. other			4.60	4.40	3.80
7. Payments to facilities providing insured hospital services, by the facility's primary type of care: ($)					
a. acute care			not available [2]	not available [2]	not available [2]
b. chronic care			not available [2]	not available [2]	not available [2]
c. rehabilitative care			not available [2]	not available [2]	not available [2]
d. out-patient diagnostic care			not available [2]	not available [2]	not available [2]
e. surgical day care (out-patient)			not available [2]	not available [2]	not available [2]
f. other			not available [2]	not available [2]	not available [2]
g. total payments to facilities providing insured hospital services			36,200,621 [2]	40,441,864 [2]	44,569,725 [2]
8. Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care: ($)					
a. acute care			not available	not available	not available
b. chronic care			not available	not available	not available
c. rehabilitative care			1,443.00	1,768.60	1,866.80
d. other			1,429.10	1,630.00	1,989.20

[2] Northwest Territories does not have facilities that provide these services as their primary type of care. Instead, the 4 hospital acute care facilities provide long term care, extended care, day surgery, out-patient services, diagnostic services and rehabilitative care.

Statistics for 1997-1998 and 1998-1999 are not provided as effective April 1, 1999, Nunavut Territory was formed from part of the Northwest Territories.

Insured Hospital Services Within Own Province or Territory						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care:	($)					
a. acute care				not available	not available	not available
b. chronic care				not available	not available	not available
c. rehabilitative care				107.30	119.40	109.80
d. out-patient diagnostic care				not available	not available	not available
e. surgical day care (out-patient)				390.10	434.90	530.40
f. other				not available	not available	not available
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care:	($)					
a. acute care				not available	not available	not available
b. chronic care				not available	not available	not available
c. rehabilitative care				148.40	176.10	169.40
d. other				not available	not available	not available
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care:	(#)					
a. private surgical facilities				0	0	0
b. private diagnostic imaging facilities				0	0	0
c. Total private for-profit health care facilities				0	0	0
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care:	(#)					
a. private surgical facilities				0	0	0
b. private diagnostic imaging facilities				0	0	0
c. Total insured hospital services provided at private for-profit health care facilities				0	0	0
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care:	($)					
a. private surgical facilities				0	0	0
b. private diagnostic imaging facilities				0	0	0
c. Total payments to private for-profit health care facilities				0	0	0

Statistics for 1997-1998 and 1998-1999 are not provided as effective April 1, 1999, Nunavut Territory was formed from part of the Northwest Territories.

Insured Hospital Services Provided to Residents in Another Province or Territory

		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
14. Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (in Canada).	(#)			1,072	951	966
15. Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (in Canada).	(#)			7,829	8,110	8,240
16. Total payments for out-of-province/territory, in-patient, insured hospital services (in Canada).	($)			7,414,381	6,739,907	7,523,039
17. Total payments for out-of-province/territory, out-patient, insured hospital services (in Canada).	($)			1,200,650	1,777,182	1,882,283
18. Average payment for out-of-province/territory, in-patient insured hospital services (in Canada).	($)			6,916.40	7,087.18	7,787.83
19. Average payment for out-of-province/territory, out-patient insured hospital services (in Canada).	($)			153.36	219.13	228.43

Insured Hospital Services Provided Outside Canada

		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
20. Total number of claims paid for out-of-country, in-patient, insured hospital services.	(#)			6	5	3
21. Total number of claims paid for out-of-country, out-patient, insured hospital services.	(#)			12	17	11
22. Total payments for out-of-country, in-patient, insured hospital services.	($)			10,606	3,747	14,313
23. Total payments for out-of-country, out-patient, insured hospital services.	($)			2,363	2,163	2,365
24. Average payment for out-of-country, in-patient insured hospital services.	($)			1,767.60	749.40	4,770.88
25. Average payment for out-of-country, out-patient insured hospital services.	($)			196.91	127.26	215.02

Statistics for 1997-1998 and 1998-1999 are not provided as effective April 1, 1999, Nunavut Territory was formed from part of the Northwest Territories.

Insured Surgical-Dental Services Within Own Province or Territory						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
26. Number of dentists participating in the health insurance plan.	(#)			not available	not available	not available
27. Number of insured surgical-dental services provided by participating dentists.	(#)			not available	not available	not available
28. Total payments to dentists for insured surgical-dental services.	($)			not available	not available	not available
29. Average payment per service for insured surgical-dental services.	($)			not available	not available	not available

Insured Physician Services Within Own Province or Territory						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
30. Number of physicians participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners				35[4]	29[4]	24[4]
b. specialists				18[4]	18[4]	13[4]
c. other				106[5]	151[5]	175[5]
d. total				159[6]	198[6]	212[6]
31. Number of physicians opted-out of the health insurance plan, by type of physician:	(#)					
a. general practitioners				0	0	0
b. specialists				0	0	0
c. other				0	0	0
d. total				0	0	0
32. Number of physicians not participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners				0	0	0
b. specialists				0	0	0
c. other				0	0	0
d. total				0	0	0

[4] Southam Medical Database, Canadian Institute for Health Information.

[5] This is an estimate of the number of locum physicians. For measures 33 through 38, locum physicians are captured within the general practioners and specialists categories.

[6] Estimate based on total active physicians for each fiscal year.

Statistics for 1997-1998 and 1998-1999 are not provided as effective April 1, 1999, Nunavut Territory was formed from part of the Northwest Territories.

Insured Physician Services Within Own Province or Territory					
	1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
33. Number of insured physician services provided, by type of physician (fee-for-service): (#)					
a. general practitioners			142,004	81,921	32,329
b. specialists			9,487	5,465	5,414
c. other			not applicable	not applicable	not applicable
d. total			151,491	87,386	37,743
34. Number of insured physician services provided, by category of service: (#)					
a. medical			not available	not available	not available
b. surgical			not available	not available	not available
c. diagnostic			not available	not available	not available
d. other			not available	not available	not available
e. total			213,664	200,198	198,347
35. Total payments to (fee-for-service) physicians for insured physician services, by type of physician: ($)					
a. general practitioners			5,589,151	3,357,203	1,225,378
b. specialists			650,639	599,067	606,615
c. other			not available	not available	not available
d. total			6,239,790	3,956,270	1,831,993
36. Total payments to physicians for insured physician services, by category of service: ($)					
a. medical			not available	not available	not available
b. surgical			not available	not available	not available
c. diagnostic			not available	not available	not available
d. other			not available	not available	not available
e. total			11,099,752	17,037,488	19,672,456
37. Average payment per service for insured (fee-for-service) physician services, by type of physician: ($)					
a. general practitioners			39.36	40.98	37.90
b. specialists			68.58	109.62	112.05
c. other			not available	not available	not available
d. all physicians			41.19	45.27	48.54
38. Average payment per service for insured physician services, by category of service: ($)					
a. medical			not available	not available	not available
b. surgical			not available	not available	not available
c. diagnostic			not available	not available	not available
d. other			not available	not available	not available
e. all services			51.90	85.10	99.20

Statistics for 1997-1998 and 1998-1999 are not provided as effective April 1, 1999, Nunavut Territory was formed from part of the Northwest Territories.

Insured Physician Services Provided to Residents in Another Province or Territory						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
39. Number of services paid for out-of-province/territory, insured physician services (in Canada)	(#)			44,473	40,077	39,164
40. Total payments for out-of-province/territory insured physician services (in Canada)	($)			2,420,420	2,779,829	2,429,575
41. Average payment per service for out-of-province/territory insured physician services (in Canada)	($)			54.42	69.36	62.04

Insured Physician Services Provided Outside Canada						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
42. Number of services paid for out-of-country, insured physician services	(#)			212	186	71
43. Total payments for out-of-country insured physician services	($)			18,819	18,171	9,425
44. Average payment per service for out-of-country insured physician services	($)			88.77	97.69	132.74

Statistics for 1997-1998 and 1998-1999 are not provided as effective April 1, 1999, Nunavut Territory was formed from part of the Northwest Territories.

Nunavut

Registered Persons					
	1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
1. Total number of persons registered under the health care insurance plan as of March 31st (#)			not available	26,829	28,630

Insured Hospital Services Within Own Province or Territory					
	1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care (#)					
a. acute care			1	1	1
b. chronic care			not available	not available	not available
c. rehabilitative care			not available	not available	not available
d. out-patient diagnostic care			not available	not available	not available
e. surgical day care (out-patient)			not available	not available	not available
f. other			25[1]	25[1]	25[1]
g. total facilities			not available	not available	not available
3. Number of staffed beds in all facilities providing insured hospital services, by type of bed (#)					
a. acute care			not available	not available	not available
b. chronic care			not available	not available	not available
c. rehabilitative care			not available	not available	not available
d. out-patient diagnostic care			not available	not available	not available
e. other			not available	not available	not available
f. total staffed beds			not available	not available	not available
4. Approved bed complement for all facilities providing insured hospital services, by type of bed (#)					
a. acute care			not available	not available	not available
b. chronic care			not available	not available	not available
c. rehabilitative care			not available	not available	not available
d. out-patient diagnostic care			not available	not available	not available
e. other			not available	not available	not available
f. total approved bed complement			not available	not available	not available

[1] Health Centres.

Statistics for 1997-1998 and 1998-1999 are not provided as Nunavut was formed April 1, 1999.

Insured Hospitals Services Within Own Province or Territory		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
5. Number of separations from all facilities providing insured hospital services, by type of care:	(#)					
a. acute care				not available	not available	not available
b. chronic care				not available	not available	not available
c. rehabilitative care				not available	not available	not available
d. out-patient diagnostic care				not available	not available	not available
e. surgical day care (out-patient)				not available	not available	not available
f. alternative level of care				not available	not available	not available
g. newborns				not available	not available	not available
h. other				not available	not available	not available
i. total separations				not available	not available	not available
6. Average length of in-patient stay in all facilities providing insured hospital services, by type of care:	(# of days)					
a. acute care				not available	not available	not available
b. chronic care				not available	not available	not available
c. rehabilitative care				not available	not available	not available
d. newborns				not available	not available	not available
e. other				not available	not available	not available
7. Payments to facilities providing insured hospital services, by the facility's primary type of care:	($)					
a. acute care				not available	not available	not available
b. chronic care				not available	not available	not available
c. rehabilitative care				not available	not available	not available
d. out-patient diagnostic care				not available	not available	not available
e. surgical day care (out-patient)				not available	not available	not available
f. other				not available	not available	not available
g. total payments to facilities providing insured hospital services				not available	not available	not available
8. Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care:	($)					
a. acute care				not available	not available	not available
b. chronic care				not available	not available	not available
c. rehabilitative care				not available	not available	not available
d. other				not available	not available	not available

Statistics for 1997-1998 and 1998-1999 are not provided as Nunavut was formed April 1, 1999.

Insured Hospital Services Within Own Province or Territory		**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**	**2001-2002**
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care:	**($)**					
a. acute care				not available	not available	not available
b. chronic care				not available	not available	not available
c. rehabilitative care				not available	not available	not available
d. out-patient diagnostic care				not available	not available	not available
e. surgical day care (out-patient)				not available	not available	not available
f. other				not available	not available	not available
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care:	**($)**					
a. acute care				not available	not available	not available
b. chronic care				not available	not available	not available
c. rehabilitative care				not available	not available	not available
d. other				not available	not available	not available
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care:	**(#)**					
a. private surgical facilities				0	0	0
b. private diagnostic imaging facilities				0	0	0
c. Total private for-profit health care facilities				0	0	0
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care:	**(#)**					
a. private surgical facilities				0	0	0
b. private diagnostic imaging facilities				0	0	0
c. Total insured hospital services provided at private for-profit health care facilities				0	0	0
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care:	**($)**					
a. private surgical facilities				0	0	0
b. private diagnostic imaging facilities				0	0	0
c. Total payments to private for-profit health care facilities				0	0	0

Statistics for 1997-1998 and 1998-1999 are not provided as Nunavut was formed April 1, 1999.

Insured Hospital Services Provided to Residents in Another Province or Territory		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
14. Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (in Canada).	(#)			1,842	1,549	1,782
15. Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (in Canada).	(#)			9,656	8,682	9,155
16. Total payments for out-of-province/territory, in-patient, insured hospital services (in Canada).	($)			8,546,013	7,612,791	7,681,154
17. Total payments for out-of-province/territory, out-patient, insured hospital services (in Canada).	($)			1,470,018	1,352,594	1,525,710
18. Average payment for out-of-province/territory, in-patient insured hospital services (in Canada).	($)			4,639.00	4,915.00	4,310.00
19. Average payment for out-of-province/territory, out-patient insured hospital services (in Canada).	($)			152.00	156.00	167.00

Insured Hospital Services Provided Outside Canada		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
20. Total number of claims paid for out-of-country, in-patient, insured hospital services.	(#)			14	0	0
21. Total number of claims paid for out-of-country, out-patient, insured hospital services.	(#)			5	1	53
22. Total payments for out-of-country, in-patient, insured hospital services.	($)			12,010	0	0
23. Total payments for out-of-country, out-patient, insured hospital services.	($)			1,130	110	128,398
24. Average payment for out-of-country, in-patient insured hospital services.	($)			857.00	0.00	0.00
25. Average payment for out-of-country, out-patient insured hospital services.	($)			226.00	110.00	2,423.00

Statistics for 1997-1998 and 1998-1999 are not provided as Nunavut was formed April 1, 1999.

Insured Surgical-Dental Services Within Own Province or Territory						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
26. Number of dentists participating in the health insurance plan.	(#)			27	21	not available
27. Number of insured surgical-dental services provided by participating dentists.	(#)			0	not available	not available
28. Total payments to dentists for insured surgical-dental services.	($)			0	not available	not available
29. Average payment per service for insured surgical-dental services.	($)			0.00	not available	not available

Insured Physician Services Within Own Province or Territory						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
30. Number of physicians participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners				85	59	81
b. specialists				79	55	67
c. other				0	0	0
d. total				164	114	148
31. Number of physicians opted-out of the health insurance plan, by type of physician:	(#)					
a. general practitioners				not available	0	0
b. specialists				not available	0	0
c. other				not available	0	0
d. total				not available	0	0
32. Number of physicians not participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners				not available	0	0
b. specialists				not available	0	0
c. other				not available	0	0
d. total				not available	0	0

Statistics for 1997-1998 and 1998-1999 are not provided as Nunavut was formed April 1, 1999.

Insured Physician Services Within Own Province or Territory

		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
33. Number of insured physician services provided, by type of physician (fee-for-service):	(#)					
a. general practitioners				not available	61,074	39,035
b. specialists				not available	29,485	19,733
c. other				not available	0	0
d. total				not available	90,559	58,768
34. Number of insured physician services provided, by category of service:	(#)					
a. medical				not available	not available	not available
b. surgical				not available	not available	not available
c. diagnostic				not available	not available	not available
d. other				not available	not available	not available
e. total				not available	not available	not available
35. Total payments to (fee-for-service) physicians for insured physician services, by type of physician:	($)					
a. general practitioners				2,323,234	2,494,221	1,943,399
b. specialists				1,146,522	1,229,811	1,042,366
c. other				not available	0	0
d. total				3,469,756	3,724,032	2,985,765
36. Total payments to physicians for insured physician services, by category of service:	($)					
a. medical				not available	not available	not available
b. surgical				not available	not available	not available
c. diagnostic				not available	not available	not available
d. other				not available	not available	not available
e. total				not available	not available	not available
37. Average payment per service for insured (fee-for-service) physician services, by type of physician:	($)					
a. general practitioners				not available	40.83	49.79
b. specialists				not available	41.00	52.82
c. other				not available	0.00	0.00
d. all physicians				not available	40.92	50.81
38. Average payment per service for insured physician services, by category of service:	($)					
a. medical				not available	not available	not available
b. surgical				not available	not available	not available
c. diagnostic				not available	not available	not available
d. other				not available	not available	not available
e. all services				not available	not available	not available

Statistics for 1997-1998 and 1998-1999 are not provided as Nunavut was formed April 1, 1999.

Insured Physician Services Provided to Residents in Another Province or Territory						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
39. Number of services paid for out-of-province/territory, insured physician services (in Canada).	(#)			not available	55,389	39,438
40. Total payments for out-of-province/territory insured physician services (in Canada).	($)			not available	3,232,940	2,335,998
41. Average payment per service for out-of-province/territory insured physician services (in Canada).	($)			not available	58.00	59.23

Insured Physician Services Provided Outside Canada						
		1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
42. Number of services paid for out-of-country, insured physician services.	(#)			0	0	12
43. Total payments for out-of-country insured physician services.	($)			0	0	14,835
44. Average payment per service for out-of-country insured physician services.	($)			0.00	0.00	1,236.00

Statistics for 1997-1998 and 1998-1999 are not provided as Nunavut was formed April 1, 1999.

Annex B – Canada Health Act and Extra-Billing and User Charges Information Regulations

This annex provides the reader with an office consolidation of the *Canada Health Act* and the Extra-billing and User Charges Information Regulations. An "office consolidation" is a rendering of the original act, which includes any amendments that have been made since the Act's passage.

The only regulations in force under the Act are the Extra-billing and User Charges Information Regulations, which require the provinces and territories to provide estimates of extra-billing and user charges prior to the beginning of each fiscal year so that appropriate penalties can be levied, as well as financial statements showing the amounts actually charged so that reconciliations with the actual deductions can be made. These regulations are also presented in an office consolidation format.

This unofficial consolidation is current to June 2001.

CANADA

OFFICE CONSOLIDATION

Canada Health Act

R.S., 1985, c. C-6

Extra-billing and User Charges Information Regulations

SOR/86-259

June, 2001

CODIFICATION ADMINISTRATIVE

Loi canadienne sur la santé

L.R. (1985), ch. C-6

Règlement concernant les renseignements sur la surfacturation et les frais modérateurs

DORS/86-259

Juin 2001

WARNING NOTE

Users of this office consolidation are reminded that it is prepared for convenience of reference only and that, as such, it has no official sanction.

AVERTISSEMENT

La présente codification administrative n'est préparée que pour la commodité du lecteur et n'a aucune valeur officielle.

OFFICE CONSOLIDATION

Canada Health Act

R.S., 1985, c. C-6

CODIFICATION ADMINISTRATIVE

Loi canadienne sur la santé

L.R. (1985), ch. C-6

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CHAPTER C-6

An Act relating to cash contributions by Canada and relating to criteria and conditions in respect of insured health services and extended health care services

Preamble

Whereas the Parliament of Canada recognizes:

—that it is not the intention of the Government of Canada that any of the powers, rights, privileges or authorities vested in Canada or the provinces under the provisions of the *Constitution Act, 1867*, or any amendments thereto, or otherwise, be by reason of this Act abrogated or derogated from or in any way impaired;

—that Canadians, through their system of insured health services, have made outstanding progress in treating sickness and alleviating the consequences of disease and disability among all income groups;

—that Canadians can achieve further improvements in their well-being through combining individual lifestyles that emphasize fitness, prevention of disease and health promotion with collective action against the social, environmental and occupational causes of disease, and that they desire a system of health services that will promote physical and mental health and protection against disease;

—that future improvements in health will require the cooperative partnership of governments, health professionals, voluntary organizations and individual Canadians;

—that continued access to quality health care without financial or other barriers will be critical to maintaining and improving the health and well-being of Canadians;

And whereas the Parliament of Canada wishes to encourage the development of health services

CHAPITRE C-6

Loi concernant les contributions pécuniaires du Canada ainsi que les principes et conditions applicables aux services de santé assurés et aux services complémentaires de santé

Préambule

Considérant que le Parlement du Canada reconnaît :

que le gouvernement du Canada n'entend pas par la présente loi abroger les pouvoirs, droits, privilèges ou autorités dévolus au Canada ou aux provinces sous le régime de la *Loi constitutionnelle de 1867* et de ses modifications ou à tout autre titre, ni leur déroger ou porter atteinte,

que les Canadiens ont fait des progrès remarquables, grâce à leur système de services de santé assurés, dans le traitement des maladies et le soulagement des affections et déficiences parmi toutes les catégories socio-économiques,

que les Canadiens peuvent encore améliorer leur bien-être en joignant à un mode de vie individuel axé sur la condition physique, la prévention des maladies et la promotion de la santé, une action collective contre les causes sociales, environnementales ou industrielles des maladies et qu'ils désirent un système de services de santé qui favorise la santé physique et mentale et la protection contre les maladies,

que les améliorations futures dans le domaine de la santé nécessiteront la coopération des gouvernements, des professionnels de la santé, des organismes bénévoles et des citoyens canadiens,

que l'accès continu à des soins de santé de qualité, sans obstacle financier ou autre, sera déterminant pour la conservation et l'amélioration de la santé et du bien-être des Canadiens, throughout Canada by assisting the provinces in meeting the costs thereof;

Now therefore, Her Majesty, by and with the advice and consent of the Senate and House of Commons of Canada, enacts as follows:

SHORT TITLE

Short title

1. This Act may be cited as the *Canada Health Act*.

1984, c. 6, s. 1.

INTERPRETATION

Definitions

2. In this Act,

"Act of 1977" [Repealed, 1995, c. 17, s. 34]

"cash contribution" *« contribution pécuniaire »*

"cash contribution" means the cash contribution in respect of the Canada Health and Social Transfer that may be provided to a province under subsections 15(1) and (4) of the *Federal-Provincial Fiscal Arrangements Act*;

"contribution" [Repealed, 1995, c. 17, s. 34]

"dentist" *«dentiste»*

"dentist" means a person lawfully entitled to practise dentistry in the place in which the practice is carried on by that person;

"extended health care services" *«services complémentaires de santé»*

"extended health care services" means the following services, as more particularly defined in the regulations, provided for residents of a province, namely,

(a) nursing home intermediate care service,

(b) adult residential care service,

(c) home care service, and

(d) ambulatory health care service;

"extra-billing" *«surfacturation»*

"extra-billing" means the billing for an insured health service rendered to an insured person by a medical practitioner or a dentist in an amount in addition to any amount paid or to be paid for that service by the health care insurance plan of a province;

"health care insurance plan" *«régime d'assurance-santé»*

"health care insurance plan" means, in relation to a province, a plan or plans established by the law of the province to provide for insured health services;

"health care practitioner" *«professionnel de la santé»*

"health care practitioner" means a person lawfully entitled under the law of a province to provide health services in the place in which the services are provided by that person;

"hospital" *«hôpital»*

"hospital" includes any facility or portion thereof that provides hospital care, including

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considérant en outre que le Parlement du Canada souhaite favoriser le développement des services de santé dans tout le pays en aidant les provinces à en supporter le coût,

Sa Majesté, sur l'avis et avec le consentement du Sénat et de la Chambre des communes du Canada, édicte :

TITRE ABRÉGÉ

Titre abrégé

1. *Loi canadienne sur la santé.*

1984, ch. 6, art. 1.

DÉFINITIONS

Définitions

2. Les définitions qui suivent s'appliquent à la présente loi.

«assuré» *"insured person"*

«assuré» Habitant d'une province, à l'exception :

a) des membres des Forces canadiennes;

b) des membres de la Gendarmerie royale du Canada nommés à un grade;

c) des personnes purgeant une peine d'emprisonnement dans un pénitencier, au sens de la Partie I de la *Loi sur le système correctionnel et la mise en liberté sous condition;*

d) des habitants de la province qui s'y trouvent depuis une période de temps inférieure au délai minimal de résidence ou de carence d'au plus trois mois imposé aux habitants par la province pour qu'ils soient admissibles ou aient droit aux services de santé assurés.

«contribution» [Abrogée, 1995, ch. 17, art. 34]

« contribution pécuniaire » *"cash contribution"*

« contribution pécuniaire » La contribution au titre du Transfert canadien en matière de santé et de programmes sociaux qui peut être versée à une province au titre des paragraphes 15(1) et (4) de la *Loi sur les arrangements fiscaux entre le gouvernement fédéral et les provinces*.

«dentiste» *"dentist"*

«dentiste» Personne légalement autorisée à exercer la médecine dentaire au lieu où elle se livre à cet exercice.

«frais modérateurs» *"user charge"*

«frais modérateurs» Frais d'un service de santé assuré autorisés ou permis par un régime provincial d'assurance-santé mais non payables, soit directement soit indirectement, au titre d'un régime provincial d'assurance-santé, à l'exception des frais imposés par surfacturation.

acute, rehabilitative or chronic care, but does not include

(a) a hospital or institution primarily for the mentally disordered, or

(b) a facility or portion thereof that provides nursing home intermediate care service or adult residential care service, or comparable services for children;

"hospital services" *« services hospitaliers »*

"hospital services" means any of the following services provided to in-patients or out-patients at a hospital, if the services are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability, namely,

(a) accommodation and meals at the standard or public ward level and preferred accommodation if medically required,

(b) nursing service,

(c) laboratory, radiological and other diagnostic procedures, together with the necessary interpretations,

(d) drugs, biologicals and related preparations when administered in the hospital,

(e) use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies,

(f) medical and surgical equipment and supplies,

(g) use of radiotherapy facilities,

(h) use of physiotherapy facilities, and

(i) services provided by persons who receive remuneration therefor from the hospital,

but does not include services that are excluded by the regulations;

"insured health services" *« services de santé assurés »*

"insured health services" means hospital services, physician services and surgical-dental services provided to insured persons, but does not include any health services that a person is entitled to and eligible for under any other Act of Parliament or under any Act of the legislature of a province that relates to workers' or workmen's compensation;

"insured person" « assuré »

"insured person" means, in relation to a province, a resident of the province other than

(a) a member of the Canadian Forces,

(b) a member of the Royal Canadian Mounted Police who is appointed to a rank therein,

«habitant» *"resident"*

«habitant» Personne domiciliée et résidant habituellement dans une province et légalement autorisée à être ou à rester au Canada, à l'exception d'une personne faisant du tourisme, de passage ou en visite dans la province.

«hôpital» *"hospital"*

«hôpital» Sont compris parmi les hôpitaux tout ou partie des établissements où sont fournis des soins hospitaliers, notamment aux personnes souffrant de maladie aiguë ou chronique ainsi qu'en matière de réadaptation, à l'exception :

a) des hôpitaux ou institutions destinés principalement aux personnes souffrant de troubles mentaux;

b) de tout ou partie des établissements où sont fournis des soins intermédiaires en maison de repos ou des soins en établissement pour adultes ou des soins comparables pour les enfants.

«loi de 1977» [Abrogée, 1995, ch. 17, art. 34]

«médecin» *"medical practitioner"*

«médecin» Personne légalement autorisée à exercer la médecine au lieu où elle se livre à cet exercice.

«ministre» *"Minister"*

«ministre» Le ministre de la Santé.

«professionnel de la santé» *"health care practitioner"*

«professionnel de la santé» Personne légalement autorisée en vertu de la loi d'une province à fournir des services de santé au lieu où elle les fournit.

«régime d'assurance-santé» *"health care insurance plan"*

«régime d'assurance-santé» Le régime ou les régimes constitués par la loi d'une province en vue de la prestation de services de santé assurés.

«services complémentaires de santé» *"extended health care services"*

«services complémentaires de santé» Les services définis dans les règlements et offerts aux habitants d'une province, à savoir :

a) les soins intermédiaires en maison de repos;

b) les soins en établissement pour adultes;

c) les soins à domicile;

d) les soins ambulatoires.

«services de chirurgie dentaire» *"surgical-dental services"*

«services de chirurgie dentaire» Actes de chirurgie dentaire nécessaires sur le plan médical ou dentaire, accomplis par un dentiste dans un hôpital, et qui ne peuvent être accomplis convenablement qu'en un tel établissement.

(c) a person serving a term of imprisonment in a penitentiary as defined in the *Penitentiary Act*, or

(d) a resident of the province who has not completed such minimum period of residence or waiting period, not exceeding three months, as may be required by the province for eligibility for or entitlement to insured health services;

"medical practitioner" *« médecin »*

"medical practitioner" means a person lawfully entitled to practise medicine in the place in which the practice is carried on by that person;

"Minister" *« ministre »*

"Minister" means the Minister of Health;

"physician services" *« services médicaux »*

"physician services" means any medically required services rendered by medical practitioners;

"resident" *« habitant »*

"resident" means, in relation to a province, a person lawfully entitled to be or to remain in Canada who makes his home and is ordinarily present in the province, but does not include a tourist, a transient or a visitor to the province;

"surgical-dental services" *« services de chirurgie dentaire »*

"surgical-dental services" means any medically or dentally required surgical-dental procedures performed by a dentist in a hospital, where a hospital is required for the proper performance of the procedures;

"user charge" *« frais modérateurs »*

"user charge" means any charge for an insured health service that is authorized or permitted by a provincial health care insurance plan that is not payable, directly or indirectly, by a provincial health care insurance plan, but does not include any charge imposed by extra-billing.

R.S., 1985, c. C-6, s. 2; 1992, c. 20, s. 216(F); 1995, c. 17, s. 34; 1996, c. 8, s. 32; 1999, c. 26, s. 11.

«services de santé assurés» *"insured health services"*

«services de santé assurés» Services hospitaliers, médicaux ou de chirurgie dentaire fournis aux assurés, à l'exception des services de santé auxquels une personne a droit ou est admissible en vertu d'une autre loi fédérale ou d'une loi provinciale relative aux accidents du travail.

«services hospitaliers» *"hospital services"*

«services hospitaliers» Services fournis dans un hôpital aux malades hospitalisés ou externes, si ces services sont médicalement nécessaires pour le maintien de la santé, la prévention des maladies ou le diagnostic ou le traitement des blessures, maladies ou invalidités, à savoir :

a) l'hébergement et la fourniture des repas en salle commune ou, si médicalement nécessaire, en chambre privée ou semi-privée;

b) les services infirmiers;

c) les actes de laboratoires, de radiologie ou autres actes de diagnostic, ainsi que les interprétations nécessaires;

d) les produits pharmaceutiques, substances biologiques et préparations connexes administrés à l'hôpital;

e) l'usage des salles d'opération, des salles d'accouchement et des installations d'anesthésie, ainsi que le matériel et les fournitures nécessaires;

f) le matériel et les fournitures médicaux et chirurgicaux;

g) l'usage des installations de radiothérapie;

h) l'usage des installations de physiothérapie;

i) les services fournis par les personnes rémunérées à cet effet par l'hôpital.

Ne sont pas compris parmi les services hospitaliers les services exclus par les règlements.

«services médicaux» *"physician services"*

«services médicaux» Services médicalement nécessaires fournis par un médecin.

«surfacturation» *"extra-billing"*

«surfacturation» Facturation de la prestation à un assuré par un médecin ou un dentiste d'un service de santé assuré, en excédent par rapport au montant payé ou à payer pour la prestation de ce service au titre du régime provincial d'assurance-santé.

L.R. (1985), ch. C-6, art. 2; 1992, ch. 20, art. 216(F); 1995, ch. 17, art. 34; 1996, ch. 8, art. 32; 1999, ch. 26, art. 11.

CANADIAN HEALTH CARE POLICY

Primary objective of Canadian health care policy

3. It is hereby declared that the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.

1984, c. 6, s. 3.

PURPOSE

Purpose of this Act

4. The purpose of this Act is to establish criteria and conditions in respect of insured health services and extended health care services provided under provincial law that must be met before a full cash contribution may be made.

R.S., 1985, c. C-6, s. 4; 1995, c. 17, s. 35.

CASH CONTRIBUTION

Cash contribution

5. Subject to this Act, as part of the Canada Health and Social Transfer, a full cash contribution is payable by Canada to each province for each fiscal year.

R.S., 1985, c. C-6, s. 5; 1995, c. 17, s. 36.

6. [Repealed, 1995, c. 17, s. 36]

PROGRAM CRITERIA

Program criteria

7. In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, the health care insurance plan of the province must, throughout the fiscal year, satisfy the criteria described in sections 8 to 12 respecting the following matters:

(a) public administration;

(b) comprehensiveness;

(c) universality;

(d) portability; and

(e) accessibility.

1984, c. 6, s. 7.

Public administration

8. (1) In order to satisfy the criterion respecting public administration,

(a) the health care insurance plan of a province must be administered and operated on a non-profit basis by a public authority appointed or designated by the government of the province;

POLITIQUE CANADIENNE DE LA SANTÉ

Objectif premier

3. La politique canadienne de la santé a pour premier objectif de protéger, de favoriser et d'améliorer le bien-être physique et mental des habitants du Canada et de faciliter un accès satisfaisant aux services de santé, sans obstacles d'ordre financier ou autre.

1984, ch. 6, art. 3.

RAISON D'ÊTRE

Raison d'être de la présente loi

4. La présente loi a pour raison d'être d'établir les conditions d'octroi et de versement d'une pleine contribution pécuniaire pour les services de santé assurés et les services complémentaires de santé fournis en vertu de la loi d'une province.

L.R. (1985), ch. C-6, art. 4; 1995, ch. 17, art. 35.

CONTRIBUTION PÉCUNIAIRE

Contribution pécuniaire

5. Sous réserve des autres dispositions de la présente loi, le Canada verse à chaque province, pour chaque exercice, une pleine contribution pécuniaire à titre d'élément du Transfert canadien en matière de santé et de programmes sociaux (ci-après, Transfert).

L.R. (1985), ch. C-6, art. 5; 1995, ch. 17, art. 36.

6. [Abrogé, 1995, ch. 17, art. 36]

CONDITIONS D'OCTROI

Règle générale

7. Le versement à une province, pour un exercice, de la pleine contribution pécuniaire visée à l'article 5 est assujetti à l'obligation pour le régime d'assurance-santé de satisfaire, pendant tout cet exercice, aux conditions d'octroi énumérées aux articles 8 à 12 quant à :

a) la gestion publique;

b) l'intégralité;

c) l'universalité;

d) la transférabilité;

e) l'accessibilité.

1984, ch. 6, art. 7.

Gestion publique

8. (1) La condition de gestion publique suppose que :

a) le régime provincial d'assurance-santé soit géré sans but lucratif par une autorité publique nommée ou désignée par le gouvernement de la province;

b) l'autorité publique soit responsable devant le gouvernement provincial de cette gestion;

(b) the public authority must be responsible to the provincial government for that administration and operation; and

(c) the public authority must be subject to audit of its accounts and financial transactions by such authority as is charged by law with the audit of the accounts of the province.

Designation of agency permitted

(2) The criterion respecting public administration is not contravened by reason only that the public authority referred to in subsection (1) has the power to designate any agency

(a) to receive on its behalf any amounts payable under the provincial health care insurance plan; or

(b) to carry out on its behalf any responsibility in connection with the receipt or payment of accounts rendered for insured health services, if it is a condition of the designation that all those accounts are subject to assessment and approval by the public authority and that the public authority shall determine the amounts to be paid in respect thereof.

1984, c. 6, s. 8.

Comprehensiveness

9. In order to satisfy the criterion respecting comprehensiveness, the health care insurance plan of a province must insure all insured health services provided by hospitals, medical practitioners or dentists, and where the law of the province so permits, similar or additional services rendered by other health care practitioners.

1984, c. 6, s. 9.

Universality

10. In order to satisfy the criterion respecting universality, the health care insurance plan of a province must entitle one hundred per cent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions.

1984, c. 6, s. 10.

Portability

11. (1) In order to satisfy the criterion respecting portability, the health care insurance plan of a province

(a) must not impose any minimum period of residence in the province, or waiting period, in excess of three months before residents of the province are eligible for or entitled to insured health services;

(b) must provide for and be administered and operated so as to provide for the payment of

c) l'autorité publique soit assujettie à la vérification de ses comptes et de ses opérations financières par l'autorité chargée par la loi de la vérification des comptes de la province.

Désignation d'un mandataire

(2) La condition de gestion publique n'est pas enfreinte du seul fait que l'autorité publique visée au paragraphe (1) a le pouvoir de désigner un mandataire chargé :

a) soit de recevoir en son nom les montants payables au titre du régime provincial d'assurance-santé;

b) soit d'exercer en son nom les attributions liées à la réception ou au règlement des comptes remis pour prestation de services de santé assurés si la désignation est assujettie à la vérification et à l'approbation par l'autorité publique des comptes ainsi remis et à la détermination par celle-ci des montants à payer à cet égard.

1984, ch. 6, art. 8.

Intégralité

9. La condition d'intégralité suppose qu'au titre du régime provincial d'assurance-santé, tous les services de santé assurés fournis par les hôpitaux, les médecins ou les dentistes soient assurés, et lorsque la loi de la province le permet, les services semblables ou additionnels fournis par les autres professionnels de la santé.

1984, ch. 6, art. 9.

Universalité

10. La condition d'universalité suppose qu'au titre du régime provincial d'assurance-santé, cent pour cent des assurés de la province ait droit aux services de santé assurés prévus par celui-ci, selon des modalités uniformes.

1984, ch. 6, art. 10.

Transférabilité

11. (1) La condition de transférabilité suppose que le régime provincial d'assurance-santé :

a) n'impose pas de délai minimal de résidence ou de carence supérieur à trois mois aux habitants de la province pour qu'ils soient admissibles ou aient droit aux services de santé assurés;

b) prévoie et que ses modalités d'application assurent le paiement des montants pour le coût des services de santé assurés fournis à amounts for the cost of insured health services provided to insured persons while temporarily absent from the province on the basis that

(i) where the insured health services are provided in Canada, payment for health services is at the rate that is approved by the health care insurance plan of the province in which the services are provided, unless the provinces concerned agree to apportion the cost between them in a different manner, or

(ii) where the insured health services are provided out of Canada, payment is made on the basis of the amount that would have been paid by the province for similar services rendered in the province, with due regard, in the case of hospital services, to the size of the hospital, standards of service and other relevant factors; and

(c) must provide for and be administered and operated so as to provide for the payment, during any minimum period of residence, or any waiting period, imposed by the health care insurance plan of another province, of the cost of insured health services provided to persons who have ceased to be insured persons by reason of having become residents of that other province, on the same basis as though they had not ceased to be residents of the province.

Requirement for consent for elective insured health services permitted

(2) The criterion respecting portability is not contravened by a requirement of a provincial health care insurance plan that the prior consent of the public authority that administers and operates the plan must be obtained for elective insured health services provided to a resident of the province while temporarily absent from the province if the services in question were available on a substantially similar basis in the province.

Definition of "elective insured health services"

(3) For the purpose of subsection (2), "elective insured health services" means insured health services other than services that are provided in an emergency or in any other circumstance in which medical care is required without delay.

1984, c. 6, s. 11.

Accessibility

12. (1) In order to satisfy the criterion respecting accessibility, the health care insurance plan of a province

des assurés temporairement absents de la province :

(i) si ces services sont fournis au Canada, selon le taux approuvé par le régime d'assurance-santé de la province où ils sont fournis, sauf accord de répartition différente du coût entre les provinces concernées,

(ii) s'il sont fournis à l'étranger, selon le montant qu'aurait versé la province pour des services semblables fournis dans la province, compte tenu, s'il s'agit de services hospitaliers, de l'importance de l'hôpital, de la qualité des services et des autres facteurs utiles;

c) prévoie et que ses modalités d'application assurent la prise en charge, pendant le délai minimal de résidence ou de carence imposé par le régime d'assurance-santé d'une autre province, du coût des services de santé assurés fournis aux personnes qui ne sont plus assurées du fait qu'elles habitent cette province, dans les mêmes conditions que si elles habitaient encore leur province d'origine.

Consentement préalable à la prestation des services de santé assurés facultatifs

(2) La condition de transférabilité n'est pas enfreinte du fait qu'il faut, aux termes du régime d'assurance-santé d'une province, le consentement préalable de l'autorité publique qui le gère pour la prestation de services de santé assurés facultatifs à un habitant temporairement absent de la province, si ces services y sont offerts selon des modalités sensiblement comparables.

Définition de «services de santé assurés facultatifs»

(3) Pour l'application du paragraphe (2), «services de santé assurés facultatifs» s'entend des services de santé assurés, à l'exception de ceux qui sont fournis d'urgence ou dans d'autres circonstances où des soins médicaux sont requis sans délai.

1984, ch. 6, art. 11.

Accessibilité

12. (1) La condition d'accessibilité suppose que le régime provincial d'assurance-santé :

a) offre les services de santé assurés selon des modalités uniformes et ne fasse pas *(a)* must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons;

(b) must provide for payment for insured health services in accordance with a tariff or system of payment authorized by the law of the province;

(c) must provide for reasonable compensation for all insured health services rendered by medical practitioners or dentists; and

(d) must provide for the payment of amounts to hospitals, including hospitals owned or operated by Canada, in respect of the cost of insured health services.

obstacle, directement ou indirectement, et notamment par facturation aux assurés, à un accès satisfaisant par eux à ces services;

b) prévoie la prise en charge des services de santé assurés selon un tarif ou autre mode de paiement autorisé par la loi de la province;

c) prévoie une rémunération raisonnable de tous les services de santé assurés fournis par les médecins ou les dentistes;

d) prévoie le versement de montants aux hôpitaux, y compris les hôpitaux que possède ou gère le Canada, à l'égard du coût des services de santé assurés.

Reasonable compensation

(2) In respect of any province in which extra-billing is not permitted, paragraph (1)*(c)* shall be deemed to be complied with if the province has chosen to enter into, and has entered into, an agreement with the medical practitioners and dentists of the province that provides

(a) for negotiations relating to compensation for insured health services between the province and provincial organizations that represent practising medical practitioners or dentists in the province;

(b) for the settlement of disputes relating to compensation through, at the option of the appropriate provincial organizations referred to in paragraph *(a)*, conciliation or binding arbitration by a panel that is equally representative of the provincial organizations and the province and that has an independent chairman; and

(c) that a decision of a panel referred to in paragraph *(b)* may not be altered except by an Act of the legislature of the province.

1984, c. 6, s. 12.

Rémunération raisonnable

(2) Pour toute province où la surfacturation n'est pas permise, il est réputé être satisfait à l'alinéa (1)*c)* si la province a choisi de conclure un accord et a effectivement conclu un accord avec ses médecins et dentistes prévoyant :

a) la tenue de négociations sur la rémunération des services de santé assurés entre la province et les organisations provinciales représentant les médecins ou dentistes qui exercent dans la province;

b) le règlement des différends concernant la rémunération par, au choix des organisations provinciales compétentes visées à l'alinéa *a)*, soit la conciliation soit l'arbitrage obligatoire par un groupe représentant également les organisations provinciales et la province et ayant un président indépendant;

c) l'impossibilité de modifier la décision du groupe visé à l'alinéa *b)*, sauf par une loi de la province.

1984, ch. 6, art. 12.

CONDITIONS FOR CASH CONTRIBUTION

Conditions

13. In order that a province may qualify for a full cash contribution referred to in section 5, the government of the province

(a) shall, at the times and in the manner prescribed by the regulations, provide the Minister with such information, of a type prescribed by the regulations, as the Minister

CONTRIBUTION PÉCUNIAIRE ASSUJETTIE À DES CONDITIONS

Obligations de la province

13. Le versement à une province de la pleine contribution pécuniaire visée à l'article 5 est assujetti à l'obligation pour le gouvernement de la province :

a) de communiquer au ministre, selon les modalités de temps et autres prévues par les règlements, les renseignements du genre may reasonably require for the purposes of this Act; and

(b) shall give recognition to the Canada Health and Social Transfer in any public documents, or in any advertising or promotional material, relating to insured health services and extended health care services in the province.

R.S., 1985, c. C-6, s. 13; 1995, c. 17, s. 37.

DEFAULTS

Referral to Governor in Council

14. (1) Subject to subsection (3), where the Minister, after consultation in accordance with subsection (2) with the minister responsible for health care in a province, is of the opinion that

(a) the health care insurance plan of the province does not or has ceased to satisfy any one of the criteria described in sections 8 to 12, or

(b) the province has failed to comply with any condition set out in section 13,

and the province has not given an undertaking satisfactory to the Minister to remedy the default within a period that the Minister considers reasonable, the Minister shall refer the matter to the Governor in Council.

Consultation process

(2) Before referring a matter to the Governor in Council under subsection (1) in respect of a province, the Minister shall

(a) send by registered mail to the minister responsible for health care in the province a notice of concern with respect to any problem foreseen;

(b) seek any additional information available from the province with respect to the problem through bilateral discussions, and make a report to the province within ninety days after sending the notice of concern; and

(c) if requested by the province, meet within a reasonable period of time to discuss the report.

Where no consultation can be achieved

(3) The Minister may act without consultation under subsection (1) if the Minister is of the opinion that a sufficient time has expired after reasonable efforts to achieve consultation and that consultation will not be achieved.

1984, c. 6, s. 14.

Order reducing or withholding contribution

15. (1) Where, on the referral of a matter under section 14, the Governor in Council is of the opinion that the health care insurance plan of

prévu aux règlements, dont celui-ci peut normalement avoir besoin pour l'application de la présente loi;

b) de faire état du Transfert dans tout document public ou toute publicité sur les services de santé assurés et les services complémentaires de santé dans la province.

L.R. (1985), ch. C-6, art. 13; 1995, ch. 17, art. 37.

MANQUEMENTS

Renvoi au gouverneur en conseil

14. (1) Sous réserve du paragraphe (3), dans le cas où il estime, après avoir consulté conformément au paragraphe (2) son homologue chargé de la santé dans une province :

a) soit que le régime d'assurance-santé de la province ne satisfait pas ou plus aux conditions visées aux articles 8 à 12;

b) soit que la province ne s'est pas conformée aux conditions visées à l'article 13,

et que celle-ci ne s'est pas engagée de façon satisfaisante à remédier à la situation dans un délai suffisant, le ministre renvoie l'affaire au gouverneur en conseil.

Étapes de la consultation

(2) Avant de renvoyer une affaire au gouverneur en conseil conformément au paragraphe (1) relativement à une province, le ministre :

a) envoie par courrier recommandé à son homologue chargé de la santé dans la province un avis sur tout problème éventuel;

b) tente d'obtenir de la province, par discussions bilatérales, tout renseignement additionnel disponible sur le problème et fait rapport à la province dans les quatre-vingt-dix jours suivant l'envoi de l'avis;

c) si la province le lui demande, tient une réunion dans un délai acceptable afin de discuter du rapport.

Impossibilité de consultation

(3) Le ministre peut procéder au renvoi prévu au paragraphe (1) sans consultation préalable s'il conclut à l'impossibilité d'obtenir cette consultation malgré des efforts sérieux déployés à cette fin au cours d'un délai convenable.

1984, ch. 6, art. 14.

Décret de réduction ou de retenue

15. (1) Si l'affaire lui est renvoyée en vertu de l'article 14 et qu'il estime que le régime d'assurance-santé de la province ne satisfait pas

a province does not or has ceased to satisfy any one of the criteria described in sections 8 to 12 or that a province has failed to comply with any condition set out in section 13, the Governor in Council may, by order,

(a) direct that any cash contribution to that province for a fiscal year be reduced, in respect of each default, by an amount that the Governor in Council considers to be appropriate, having regard to the gravity of the default; or

(b) where the Governor in Council considers it appropriate, direct that the whole of any cash contribution to that province for a fiscal year be withheld.

Amending orders

(2) The Governor in Council may, by order, repeal or amend any order made under subsection (1) where the Governor in Council is of the opinion that the repeal or amendment is warranted in the circumstances.

Notice of order

(3) A copy of each order made under this section together with a statement of any findings on which the order was based shall be sent forthwith by registered mail to the government of the province concerned and the Minister shall cause the order and statement to be laid before each House of Parliament on any of the first fifteen days on which that House is sitting after the order is made.

Commencement of order

(4) An order made under subsection (1) shall not come into force earlier than thirty days after a copy of the order has been sent to the government of the province concerned under subsection (3).

R.S., 1985, c. C-6, s. 15; 1995, c. 17, s. 38.

Reimposition of reductions or withholdings

16. In the case of a continuing failure to satisfy any of the criteria described in sections 8 to 12 or to comply with any condition set out in section 13, any reduction or withholding under section 15 of a cash contribution to a province for a fiscal year shall be reimposed for each succeeding fiscal year as long as the Minister is satisfied, after consultation with the minister responsible for health care in the province, that the default is continuing.

R.S., 1985, c. C-6, s. 16; 1995, c. 17, s. 39.

When reduction or withholding imposed

17. Any reduction or withholding under section 15 or 16 of a cash contribution may be imposed in the fiscal year in which the default

ou plus aux conditions visées aux articles 8 à 12 ou que la province ne s'est pas conformée aux conditions visées à l'article 13, le gouverneur en conseil peut, par décret :

a) soit ordonner, pour chaque manquement, que la contribution pécuniaire d'un exercice à la province soit réduite du montant qu'il estime indiqué, compte tenu de la gravité du manquement;

b) soit, s'il l'estime indiqué, ordonner la retenue de la totalité de la contribution pécuniaire d'un exercice à la province.

Modification des décrets

(2) Le gouverneur en conseil peut, par décret, annuler ou modifier un décret pris en vertu du paragraphe (1) s'il l'estime justifié dans les circonstances.

Avis

(3) Le texte de chaque décret pris en vertu du présent article de même qu'un exposé des motifs sur lesquels il est fondé sont envoyés sans délai par courrier recommandé au gouvernement de la province concernée; le ministre fait déposer le texte du décret et celui de l'exposé devant chaque chambre du Parlement dans les quinze premiers jours de séance de celle-ci suivant la prise du décret.

Entrée en vigueur du décret

(4) Un décret pris en vertu du paragraphe (1) ne peut entrer en vigueur que trente jours après l'envoi au gouvernement de la province concernée du texte du décret aux termes du paragraphe (3).

L.R. (1985), ch. C-6, art. 15; 1995, ch. 17, art. 38.

Nouvelle application des réductions ou retenues

16. En cas de manquement continu aux conditions visées aux articles 8 à 12 ou à l'article 13, les réductions ou retenues de la contribution pécuniaire à une province déjà appliquées pour un exercice en vertu de l'article 15 lui sont appliquées de nouveau pour chaque exercice ultérieur où le ministre estime, après consultation de son homologue chargé de la santé dans la province, que le manquement se continue.

L.R. (1985), ch. C-6, art. 16; 1995, ch. 17, art. 39.

Application aux exercices ultérieurs

17. Toute réduction ou retenue d'une contribution pécuniaire visée aux articles 15 ou 16 peut être appliquée pour l'exercice où le that gave rise to the reduction or withholding occurred or in the following fiscal year.

R.S., 1985, c. C-6, s. 17; 1995, c. 17, s. 39.

EXTRA-BILLING AND USER CHARGES

Extra-billing

18. In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, no payments may be permitted by the province for that fiscal year under the health care insurance plan of the province in respect of insured health services that have been subject to extra-billing by medical practitioners or dentists.

1984, c. 6, s. 18.

User charges

19. (1) In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, user charges must not be permitted by the province for that fiscal year under the health care insurance plan of the province.

Limitation

(2) Subsection (1) does not apply in respect of user charges for accommodation or meals provided to an in-patient who, in the opinion of the attending physician, requires chronic care and is more or less permanently resident in a hospital or other institution.

1984, c. 6, s. 19.

Deduction for extra-billing

20. (1) Where a province fails to comply with the condition set out in section 18, there shall be deducted from the cash contribution to the province for a fiscal year an amount that the Minister, on the basis of information provided in accordance with the regulations, determines to have been charged through extra-billing by medical practitioners or dentists in the province in that fiscal year or, where information is not provided in accordance with the regulations, an amount that the Minister estimates to have been so charged.

Deduction for user charges

(2) Where a province fails to comply with the condition set out in section 19, there shall be deducted from the cash contribution to the province for a fiscal year an amount that the Minister, on the basis of information provided in accordance with the regulations, determines to have been charged in the province in respect of user charges to which section 19 applies in that fiscal year or, where information is not provided in accordance with the regulations, an amount that the Minister estimates to have been so charged.

manquement à son origine a eu lieu ou pour l'exercice suivant.

L.R. (1985), ch. C-6, art. 17; 1995, ch. 17, art. 39.

SURFACTURATION ET FRAIS MODÉRATEURS

Surfacturation

18. Une province n'a droit, pour un exercice, à la pleine contribution pécuniaire visée à l'article 5 que si, aux termes de son régime d'assurance-santé, elle ne permet pas pour cet exercice le versement de montants à l'égard des services de santé assurés qui ont fait l'objet de surfacturation par les médecins ou les dentistes.

1984, ch. 6, art. 18.

Frais modérateurs

19. (1) Une province n'a droit, pour un exercice, à la pleine contribution pécuniaire visée à l'article 5 que si, aux termes de son régime d'assurance-santé, elle ne permet pour cet exercice l'imposition d'aucuns frais modérateurs.

Réserve

(2) Le paragraphe (1) ne s'applique pas aux frais modérateurs imposés pour l'hébergement ou les repas fournis à une personne hospitalisée qui, de l'avis du médecin traitant, souffre d'une maladie chronique et séjourne de façon plus ou moins permanente à l'hôpital ou dans une autre institution.

1984, ch. 6, art. 19.

Déduction en cas de surfacturation

20. (1) Dans le cas où une province ne se conforme pas à la condition visée à l'article 18, il est déduit de la contribution pécuniaire à cette dernière pour un exercice un montant, déterminé par le ministre d'après les renseignements fournis conformément aux règlements, égal au total de la surfacturation effectuée par les médecins ou les dentistes dans la province pendant l'exercice ou, si les renseignements n'ont pas été fournis conformément aux règlements, un montant estimé par le ministre égal à ce total.

Déduction en cas de frais modérateurs

(2) Dans le cas où une province ne se conforme pas à la condition visée à l'article 19, il est déduit de la contribution pécuniaire à cette dernière pour un exercice un montant, déterminé par le ministre d'après les renseignements fournis conformément aux règlements, égal au total des frais modérateurs assujettis à l'article 19 imposés dans la province pendant l'exercice ou, si les renseignements n'ont pas été fournis conformément aux règlements, un montant estimé par le ministre égal à ce total.

Consultation with province

(3) The Minister shall not estimate an amount under subsection (1) or (2) without first undertaking to consult the minister responsible for health care in the province concerned.

Separate accounting in Public Accounts

(4) Any amount deducted under subsection (1) or (2) from a cash contribution in any of the three consecutive fiscal years the first of which commences on April 1, 1984 shall be accounted for separately in respect of each province in the Public Accounts for each of those fiscal years in and after which the amount is deducted.

Refund to province

(5) Where, in any of the three fiscal years referred to in subsection (4), extra-billing or user charges have, in the opinion of the Minister, been eliminated in a province, the total amount deducted in respect of extra-billing or user charges, as the case may be, shall be paid to the province.

Saving

(6) Nothing in this section restricts the power of the Governor in Council to make any order under section 15.

1984, c. 6, s. 20

When deduction made

21. Any deduction from a cash contribution under section 20 may be made in the fiscal year in which the matter that gave rise to the deduction occurred or in the following two fiscal years.

1984, c. 6, s. 21

REGULATIONS

Regulations

22. (1) Subject to this section, the Governor in Council may make regulations for the administration of this Act and for carrying its purposes and provisions into effect, including, without restricting the generality of the foregoing, regulations

(a) defining the services referred to in paragraphs *(a)* to *(d)* of the definition "extended health care services" in section 2;

(b) prescribing the services excluded from hospital services;

(c) prescribing the types of information that the Minister may require under paragraph 13*(a)* and the times at which and the manner in which that information shall be provided; and

(d) prescribing the manner in which recognition to the Canada Health and Social Transfer is required to be given under paragraph 13*(b)*.

Consultation de la province

(3) Avant d'estimer un montant visé au paragraphe (1) ou (2), le ministre se charge de consulter son homologue responsable de la santé dans la province concernée.

Comptabilisation

(4) Les montants déduits d'une contribution pécuniaire en vertu des paragraphes (1) ou (2) pendant les trois exercices consécutifs dont le premier commence le 1er avril 1984 sont comptabilisés séparément pour chaque province dans les comptes publics pour chacun de ces exercices pendant et après lequel le montant a été déduit.

Remboursement à la province

(5) Si, de l'avis du ministre, la surfacturation ou les frais modérateurs ont été supprimés dans une province pendant l'un des trois exercices visés au paragraphe (4), il est versé à cette dernière le montant total déduit à l'égard de la surfacturation ou des frais modérateurs, selon le cas.

Réserve

(6) Le présent article n'a pas pour effet de limiter le pouvoir du gouverneur en conseil de prendre le décret prévu à l'article 15.

1984, ch. 6, art. 20

Application aux exercices ultérieurs

21. Toute déduction d'une contribution pécuniaire visée à l'article 20 peut être appliquée pour l'exercice où le fait à son origine a eu lieu ou pour les deux exercices suivants.

1984, ch. 6, art. 21

RÈGLEMENTS

Règlements

22. (1) Sous réserve des autres dispositions du présent article, le gouverneur en conseil peut, par règlement, prendre toute mesure d'application de la présente loi et, notamment :

a) définir les services visés aux alinéas *a)* à *d)* de la définition de «services complémentaires de santé» à l'article 2;

b) déterminer les services exclus des services hospitaliers;

c) déterminer les genres de renseignements dont peut avoir besoin le ministre en vertu de l'alinéa 13*a)* et fixer les modalités de temps et autres de leur communication;

d) prévoir la façon dont il doit être fait état du Transfert en vertu de l'alinéa 13*b)*.

Agreement of provinces

(2) Subject to subsection (3), no regulation may be made under paragraph (1)*(a)* or *(b)* except with the agreement of each of the provinces.

Exception

(3) Subsection (2) does not apply in respect of regulations made under paragraph (1)*(a)* if they are substantially the same as regulations made under the *Federal-Provincial Fiscal Arrangements Act*, as it read immediately before April 1, 1984.

Consultation with provinces

(4) No regulation may be made under paragraph (1)*(c)* or *(d)* unless the Minister has first consulted with the ministers responsible for health care in the provinces.

R.S., 1985, c. C-6, s. 22; 1995, c. 17, s. 40.

REPORT TO PARLIAMENT

Annual report by Minister

23. The Minister shall, as soon as possible after the termination of each fiscal year and in any event not later than December 31 of the next fiscal year, make a report respecting the administration and operation of this Act for that fiscal year, including all relevant information on the extent to which provincial health care insurance plans have satisfied the criteria, and the extent to which the provinces have satisfied the conditions, for payment under this Act and shall cause the report to be laid before each House of Parliament on any of the first fifteen days on which that House is sitting after the report is completed.

1984, c. 6, s. 23.

(2) Sous réserve du paragraphe (3), il ne peut être pris de règlements en vertu des alinéas (1)*a)* ou *b)* qu'avec l'accord de chaque province.

Consentement des provinces

(3) Le paragraphe (2) ne s'applique pas aux règlements pris en vertu de l'alinéa (1)*a)* s'ils sont sensiblement comparables aux règlements pris en vertu de la *Loi sur les arrangements fiscaux entre le gouvernement fédéral et les provinces*, dans sa version précédant immédiatement le 1er avril 1984.

Exception

(4) Il ne peut être pris de règlements en vertu des alinéas (1)*c)* ou *d)* que si le ministre a au préalable consulté ses homologues chargés de la santé dans les provinces.

Consultation des provinces

L.R. (1985), ch. C-6, art. 22; 1995, ch. 17, art. 40.

RAPPORT AU PARLEMENT

23. Au plus tard pour le 31 décembre de chaque année, le ministre établit dans les meilleurs délais un rapport sur l'application de la présente loi au cours du précédent exercice, en y incluant notamment tous les renseignements pertinents sur la mesure dans laquelle les régimes provinciaux d'assurance-santé et les provinces ont satisfait aux conditions d'octroi et de versement prévues à la présente loi; le ministre fait déposer le rapport devant chaque chambre du Parlement dans les quinze premiers jours de séance de celle-ci suivant son achèvement.

Rapport annuel du ministre

1984, ch. 6, art. 23.

OFFICE CONSOLIDATION

CODIFICATION ADMINISTRATIVE

Extra-billing and User Charges Information Regulations

Règlement concernant les renseignements sur la surfacturation et les frais modérateurs

SOR/86-259

DORS/86-259

WARNING NOTE

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AVERTISSEMENT

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REGULATIONS PRESCRIBING THE TYPES OF INFORMATION THAT THE MINISTER OF NATIONAL HEALTH AND WELFARE MAY REQUIRE UNDER PARAGRAPH 13(*a*) OF THE CANADA HEALTH ACT IN RESPECT OF EXTRA-BILLING AND USER CHARGES AND THE TIMES AT WHICH AND THE MANNER IN WHICH SUCH INFORMATION SHALL BE PROVIDED BY THE GOVERNMENT OF EACH PROVINCE

SHORT TITLE

1. These Regulations may be cited as the *Extra-billing and User Charges Information Regulations*.

INTERPRETATION

2. In these Regulations,

"Act" means the *Canada Health Act*; *(Loi)*

"Minister" means the Minister of National Health and Welfare; *(ministre)*

"fiscal year" means the period beginning on April 1 in one year and ending on March 31 in the following year. *(exercice)*

TYPES OF INFORMATION

3. For the purposes of paragraph 13*(a)* of the Act, the Minister may require the government of a province to provide the Minister with information of the following types with respect to extra-billing in the province in a fiscal year:

(a) an estimate of the aggregate amount that, at the time the estimate is made, is expected to be charged through extra-billing, including an explanation regarding the method of determination of the estimate; and

(b) a financial statement showing the aggregate amount actually charged through extra-billing, including an explanation regarding the method of determination of the aggregate amount.

4. For the purposes of paragraph 13*(a)* of the Act, the Minister may require the government of a province to provide the Minister with information of the following types with respect to user charges in the province in a fiscal year:

(a) an estimate of the aggregate amount that, at the time the estimate is made, is expected to be charged in respect of user charges to which section 19 of the Act applies, including an explanation regarding the method of determination of the estimate; and

(b) a financial statement showing the aggregate amount actually charged in respect of user charges to which section 19 of the Act applies, including an explanation regarding the method of determination of the aggregate amount.

RÈGLEMENT DÉTERMINANT LES GENRES DE RENSEIGNEMENTS DONT PEUT AVOIR BESOIN LE MINISTRE DE LA SANTÉ NATIONALE ET DU BIEN-ÊTRE SOCIAL EN VERTU DE L'ALINÉA 13*a)* DE LA LOI CANADIENNE SUR LA SANTÉ QUANT À LA SURFACTURATION ET AUX FRAIS MODÉRATEURS ET FIXANT LES MODALITÉS DE TEMPS ET LES AUTRES MODALITÉS DE LEUR COMMUNICATION PAR LE GOUVERNEMENT DE CHAQUE PROVINCE

TITRE ABRÉGÉ

1. *Règlement concernant les renseignements sur la surfacturation et les frais modérateurs.*

DÉFINITIONS

2. Les définitions qui suivent s'appliquent au présent règlement.

«exercice» La période commençant le 1er avril d'une année et se terminant le 31 mars de l'année suivante. *(fiscal year)*

«Loi» La *Loi canadienne sur la santé*. *(Act)*

«ministre» Le ministre de la Santé nationale et du Bien-être social. *(Minister)*

GENRE DE RENSEIGNEMENTS

3. Pour l'application de l'alinéa 13*a)* de la Loi, le ministre peut exiger que le gouvernement d'une province lui fournisse les renseignements suivants sur les montants de la surfacturation pratiquée dans la province au cours d'un exercice :

a) une estimation du montant total de la surfacturation, à la date de l'estimation, accompagnée d'une explication de la façon dont cette estimation a été obtenue;

b) un état financier indiquant le montant total de la surfacturation effectivement imposée, accompagné d'une explication de la façon dont cet état a été établi.

4. Pour l'application de l'alinéa 13*a)* de la Loi, le ministre peut exiger que le gouvernement d'une province lui fournisse les renseignements suivants sur les montants des frais modérateurs imposés dans la province au cours d'un exercice :

a) une estimation du montant total, à la date de l'estimation, des frais modérateurs visés à l'article 19 de la Loi, accompagnée d'une explication de la façon dont cette estimation a été obtenue;

b) un état financier indiquant le montant total des frais modérateurs visés à l'article 19 de la Loi effectivement imposés dans la province, accompagné d'une explication de la façon dont le bilan a été établi.

TIMES AND MANNER OF FILING INFORMATION

5. (1) The government of a province shall provide the Minister with such information, of the types prescribed by sections 3 and 4, as the Minister may reasonably require, at the following times:

(a) in respect of the estimates referred to in paragraphs 3*(a)* and 4*(a)*, before April 1 of the fiscal year to which they relate; and

(b) in respect of the financial statements referred to in paragraphs 3*(b)* and 4*(b)*, before the sixteenth day of the twenty-first month following the end of the fiscal year to which they relate.

(2) The government of a province may, at its discretion, provide the Minister with adjustments to the estimates referred to in paragraphs 3*(a)* and 4*(a)* before February 16 of the fiscal year to which they relate.

(3) The information referred to in subsections (1) and (2) shall be transmitted to the Minister by the most practical means of communication.

COMMUNICATION DE RENSEIGNEMENTS

5. (1) Le gouvernement d'une province doit communiquer au ministre les renseignements visés aux articles 3 et 4, dont le ministre peut normalement avoir besoin, selon l'échéancier suivant :

a) pour les estimations visées aux alinéas 3*a)* et 4*a)*, avant le 1er avril de l'exercice visé par ces estimations;

b) pour les états financiers visés aux alinéas 3*b)* et 4*b)*, avant le seizième jour du vingt et unième mois qui suit la fin de l'exercice visé par ces états.

(2) Le gouvernement d'une province peut, à sa discrétion, fournir au ministre des ajustements aux estimations prévues aux alinéas 3*a)* et 4*a)*, avant le 16 février de l'année financière visée par ces estimations.

(3) Les renseignements visés aux paragraphes (1) et (2) doivent être expédiés au ministre par le moyen de communication le plus pratique.

Annex C - Policy Interpretation Letters

There are two key policy statements that clarify the federal position on the *Canada Health Act*. These statements have been made in the form of ministerial letters from former Federal Health Ministers to their provincial and territorial counterparts.

Epp Letter

In June 1985, approximately one year following the passage of the *Canada Health Act* in Parliament, then-federal Health Minister Jake Epp wrote to his provincial and territorial counterparts to set out and confirm the federal position on the interpretation and implementation of the *Canada Health Act*.

Minister Epp's letter followed several months of consultation with his provincial and territorial counterparts. The letter sets forth statements of federal policy intent which clarify the criteria, conditions and regulatory provisions of the CHA. These clarifications have been used by the federal government in the assessment and interpretation of compliance with the Act. The Epp letter remains an important reference for interpretation of the Act.

Federal Policy on Private Clinics

Between February 1994 and December 1994, a series of seven federal/provincial/territorial meetings dealing wholly or in part with private clinics took place. At issue was the growth of private clinics providing medically necessary services funded partially by the public system and partially by patients and its impact on Canada's universal, publicly funded health care system.

At the Federal/Provincial/Territorial Health Ministers Meeting of September 1994 in Halifax all ministers of health present, with the exception of Alberta's health minister, agreed to "take whatever steps are required to regulate the development of private clinics in Canada."

Diane Marleau, the federal Minister of Health at the time, wrote to all provincial and territorial ministers of health on January 6, 1995 to announce the new Federal Policy on Private Clinics. The Minister's letter provided the federal interpretation of the *Canada Health Act* as it relates to the issue of facility fees charged directly to patients receiving medically necessary services at private clinics. The letter stated that the definition of "hospital" contained in the *Canada Health Act*, includes any public facility that provides acute, rehabilitative or chronic care. Thus, when a provincial/territorial health insurance plan pays the physician fee for a medically necessary service delivered at a private clinic, it must also pay the facility fee or face a deduction from federal transfer payments.

[Following is the text of the letter sent on June 18, 1985 to all provincial and territorial Ministers of Health by the Honourable Jake Epp, Federal Minister of Health and Welfare. (Note: Minister Epp sent the French equivalent of this letter to Quebec on July 15, 1985.)]

June 18, 1985

OTTAWA, K1A 0K9

Sent to all Ministers of Health (except the Minister for Quebec, who received an equivalent letter in French on July 15, 1985)

Dear Minister:

Having consulted with all provincial and territorial Ministers of Health over the past several months, both individually and at the meeting in Winnipeg on May 16 and 17, I would like to confirm for you my intentions regarding the interpretation and implementation of the Canada Health Act. I would particularly appreciate if you could provide me with a written indication of your views on the attached proposals for regulations in order that I may act to have these officially put in place as soon as conveniently possible. Also, I will write to you further with regard to the material I will need to prepare the required annual report to Parliament.

As indicated at our meeting in Winnipeg, I intend to honour and respect provincial jurisdiction and authority in matters pertaining to health and the provision of health care services. I am persuaded, by conviction and experience, that more can be achieved through harmony and collaboration than through discord and confrontation.

With regard to the Canada Health Act, I can only conclude from our discussions that we together share a public trust and are mutually and equally committed to the maintenance and improvement of a universal, comprehensive, accessible and portable health insurance system, operated under public auspices for the benefit of all residents of Canada.

Our discussions have reinforced my belief that you require sufficient flexibility and administrative versatility to operate and administer your health care insurance plans. You know far better than I ever can, the needs and priori-ties of your residents, in light of geographic and economic considerations. Moreover, it is essential that provinces have the freedom to exercise their primary responsibility for the provision of personal health care services.

At the same time, I have come away from our discussions sensing a desire to sustain a positive federal involvement and role - both financial and otherwise - to support and assist provinces in their efforts dedicated to the fundamental objectives of the health care system: protecting, promoting and restoring the physical and mental well-being of Canadians. As a group, provincial/territorial Health Ministers accept a co-operative partnership with the federal government based primarily on the contributions it authorizes for purposes of providing insured and extended health care services.

I might also say that the Canada Health Act does not respond to challenges facing the health care system. I look forward to working collaboratively with you as we address challenges such as rapidly advancing medical technology and an aging population and strive to develop health promotion strategies and health care delivery alternatives.

Returning to the immediate challenge of implementing the Canada Health Act, I want to set forth some reasonably comprehensive statements of federal policy intent, beginning with each of the criteria contained in the Act.

Public Administration

This criterion is generally accepted. The intent is that the provincial health care insurance plans be administered by a public authority, accountable to the provincial government for decision-making on benefit levels and services, and whose records and accounts are publicly audited.

Comprehensiveness

The intent of the Canada Health Act is neither to expand nor contract the range of insured services covered under previous federal legislation. The range of insured services encompasses medically necessary hospital care, physician services and surgical-dental services which require a hospital for their proper performance. Hospital plans are expected to cover in-patient and out-patient hospital services associated with the provision of acute, rehabilitative and chronic care. As regards physician services, the range of insured services generally encompasses medically required services rendered by licensed medical practitioners as well as surgical-dental procedures that require a hospital for proper performance. Services rendered by other health care practitioners, except those required to provide necessary hospital services, are not subject to the Act's criteria.

Within these broad parameters, provinces, along with medical professionals, have the prerogative and responsibility for interpreting what physician services are medically necessary. As well, provinces determine which hospitals and hospital services are required to provide acute, rehabilitative or chronic care.

Universality

The intent of the Canada Health Act is to ensure that all bona-fide residents of all provinces be entitled to coverage and to the benefits under one of the twelve provincial/territorial health care insurance plans. However, eligible residents do have the option not to participate under a provincial plan should they elect to do so.

The Agreement on Eligibility and Portability provides some helpful guidelines with respect to the determination of residency status and arrangements for obtaining and maintaining coverage. Its provisions are compatible with the Canada Health Act.

I want to say a few words about premiums. Unquestionably, provinces have the right to levy taxes and the Canada Health Act does not infringe upon that right. A premium scheme per se is not precluded by the Act, provided that the provincial health care insurance plan is operated and administered in a manner that does not deny coverage or preclude access to necessary hospital and physician services to bona-fide residents of a province. Administrative arrangements should be such that residents are not precluded from or do not forego coverage by reason of an inability to pay premiums.

I am acutely aware of problems faced by some provinces in regard to tourists and visitors who may require health services while travelling in Canada. I will be undertaking a review of the current practices and procedures with my Cabinet colleagues, the Minister of External Affairs, and the Minister of Employment and Immigration, to ensure all reasonable means are taken to inform prospective visitors to Canada of the need to protect themselves with adequate health insurance coverage before entering the country.

In summary, I believe all of us as Ministers of Health are committed to the objective of ensuring that all duly qualified residents of a province obtain and retain entitlement to insured health services on uniform terms and conditions.

Portability

The intent of the portability provisions of the Canada Health Act is to provide insured persons continuing protection under their provincial health care insurance plan when they are temporarily absent from their province of residence or when moving from province to province. While temporarily in another province of Canada, bona-fide residents should not be subject to out-of-pocket costs or charges for necessary hospital and physician services. Providers should be assured of reasonable levels of payment in respect of the cost of those services.

Insofar as insured services received while outside of Canada are concerned, the intent is to assure reasonable indemnification in respect of the cost of necessary emergency hospital or physician services or for referred services not available in a province or in neighbouring provinces. Generally speaking, payment formulae tied to what would have been paid for similar services in a province would be acceptable for purposes of the Canada Health Act.

In my discussions with provincial/territorial Ministers, I detected a desire to achieve these portability objectives and to minimize the difficulties that Canadians may encounter when moving or travelling about in Canada. In order that Canadians may maintain their health insurance coverage and obtain benefits or services without undue impediment, I believe that all provincial/territorial Health Ministers are interested in seeing these services provided more efficiently and economically.

Significant progress has been made over the past few years by way of reciprocal arrangements which contribute to the achievement of the in-Canada portability objectives of the Canada Health Act. These arrangements do not interfere with the rights and prerogatives of provinces to determine and provide the coverage for services rendered in another province. Likewise, they do not deter provinces from exercising reasonable controls through prior approval mechanisms for elective procedures. I recognize that work remains to be done respecting inter-provincial payment arrangements to achieve this objective, especially as it pertains to physician services.

I appreciate that all difficulties cannot be resolved overnight and that provincial plans will require sufficient time to meet the objective of ensuring no direct charges to patients for necessary hospital and physician services provided in other provinces.

For necessary services provided out-of-Canada, I am confident that we can establish acceptable standards of indemnification for essential physician and hospital services. The legislation does not define a particular formula and I would be pleased to have your views.

In order that our efforts can progress in a co-ordinated manner, I would propose that the Federal-Provincial Advisory Committee on Institutional and Medical Services be charged with examining various options and recommending arrangements to achieve the objectives within one year.

Reasonable Accessibility

The Act is fairly clear with respect to certain aspects of accessibility. The Act seeks to discourage all point-of-service charges for insured services provided to insured persons and to prevent adverse discrimination against any population group with respect to charges for, or necessary use of, insured services. At the same time, the Act accents a partnership between the providers of insured services and provincial plans, requiring that provincial plans have in place reasonable systems of payment or compensation for their medical practitioners in order to ensure reasonable access to users. I want to emphasize my intention to respect provincial prerogatives regarding the organization, licensing, supply, distribution of health manpower, as well as the resource allocation and priorities for health services. I want to assure you that the reasonable access provision will not be used to intervene or interfere directly in matters such as the physical and geographic availability of services or provincial governance of the institutions and professions that provide insured services. Inevitably, major issues or concerns regarding access to health care services will come to my attention. I want to assure you that my Ministry will work through and with provincial/territorial Ministers in addressing such matters.

My aim in communicating my intentions with respect to the criteria in the Canada Health Act is to allow us to work together in developing our national health insurance scheme. Through continuing dialogue, open and willing exchange of information and mutually understood rules of the road, I believe that we can implement the Canada Health Act without acrimony and conflict. It is my preference that provincial/territorial Ministers themselves be given an opportunity to interpret and apply the criteria of the Canada Health Act to their respective health care insurance plans. At the same time, I believe that all provincial/ territorial Health Ministers understand and respect my accountability to the Parliament of Canada, including an annual report on the operation of provincial health care insurance plans with regard to these fundamental criteria.

Conditions

This leads me to the conditions related to the recognition of federal contributions and to the provision of information, both of which may be specified in regulations. In these matters, I will be guided by the following principles:

1. to make as few regulations as possible and only if absolutely necessary;
2. to rely on the goodwill of Ministers to afford appropriate recognition of Canada's role and contribution and to provide necessary information voluntarily for purposes of administering the Act and reporting to Parliament;
3. to employ consultation processes and mutually beneficial information exchanges as the preferred ways and means of implementing and administering the Canada Health Act;
4. to use existing means of exchanging information of mutual benefit to all our governments.

Regarding recognition by provincial/territorial governments of federal health contributions, I am satisfied that we can easily agree on appropriate recognition, in the normal course of events. The best form of recognition in my view is the demonstration to the public that as Ministers of Health we are working together in the interests of the taxpayer and patient.

In regard to information, I remain committed to maintaining and improving national data systems on a collaborative and co-operative basis. These systems serve many purposes and provide governments, as well as other agencies, organizations, and the general public, with essential data about our health care system and the health status of our population. I foresee a continuing, co-operative partnership committed to maintaining and improving health information systems in such areas as morbidity, mortality, health status, health services operations, utilization, health care costs and financing.

I firmly believe that the federal government need not regulate these matters. Accordingly, I do not intend to use the regulatory authority respecting information requirements under the Canada Health Act to expand, modify or change these broad-based data systems and exchanges. In order to keep information flows related to the Canada Health Act to an economical minimum, I see only two specific and essential information transfer mechanisms:

1. estimates and statements on extra-billing and user charges;
2. an annual provincial statement (perhaps in the form of a letter to me) to be submitted approximately six months after the completion of each fiscal year, describing the respective provincial health care insurance plan's operations as they relate to the criteria and conditions of the Canada Health Act.

Concerning Item 1 above, I propose to put in place on-going regulations that are identical in content to those that have been accepted for 1985-86. Draft regulations are attached as Annex I. To assist with the preparation of the "annual provincial statement" referred to in Item 2 above, I have developed the general guidelines attached as Annex II. Beyond these specific exchanges, I am confident that voluntary, mutually beneficial exchange of such subjects as Acts, regulations and program descriptions will continue.

One matter brought up in the course of our earlier meetings, is the question of whether estimates or deductions of user charges and extra-billing should be based on "amounts charged" or "amounts collected". The Act clearly states that deductions are to be based on amounts charged. However, with respect to user fees, certain provincial plans appear to pay these charges indirectly on behalf of certain individuals. Where a provincial plan demonstrates that it reimburses providers for amounts charged but not collected, say in respect of social assistance recipients or unpaid accounts, consideration will be given to adjusting estimates/deductions accordingly.

I want to emphasize that where a provincial plan does authorize user charges, the entire scheme must be consistent with the intent of the reasonable accessibility criterion as set forth on page 6.

Regulations

Aside from the recognition and information regulations referred to above, the Act provides for regulations concerning hospital services exclusions and regulations defining extended health care services.

As you know, the Act provides that there must be consultation and agreement of each and every province with respect to such regulations. My consultations with you have brought to light few concerns with the attached draft set of Exclusions from Hospital Services Regulations.

Likewise, I did not sense concerns with proposals for regulations defining Extended Health Care Services. These help provide greater clarity for provinces to interpret and administer current plans and programs. They do not alter significantly or substantially those that have been in force for eight years under Part VI of the Federal Post-Secondary Education and Health Contributions Act (1977). It may well be, however, as we begin to examine the future challenges to health care that we should re-examine these definitions.

This letter strives to set out flexible, reasonable and clear ground rules to facilitate provincial, as much as federal, administration of the Canada Health Act. It encompasses many complex matters including criteria interpretations, federal policy concerning conditions and proposed regulations. I realize, of course, that a letter of this sort cannot cover every single matter of concern to every provincial Minister of Health. Continuing dialogue and communication are essential.

In conclusion, may I express my appreciation for your assistance in bringing about what I believe is a generally accepted concurrence of views in respect of interpretation and implementation. As I mentioned at the outset of this letter, I would appreciate an early written indication of your views on the proposals for regulations appended to this letter. It is my intention to write to you in the near future with regard to the voluntary information exchanges which we have discussed in relation to administering the Act and reporting to Parliament.

Yours truly,

Jake Epp
Minister of Health

Attachments

[Following is the text of the letter sent on January 6, 1995 to all provincial and territorial Ministers of Health by the Federal Minister of Health, the Honourable Diane Marleau.]

January 6, 1995

Dear Minister:

RE: *Canada Health Act*

The *Canada Health Act* has been in force now for just over a decade. The principles set out in the Act (public administration, comprehensiveness, universality, portability and accessibility) continue to enjoy the support of all provincial and territorial governments. This support is shared by the vast majority of Canadians. At a time when there is concern about the potential erosion of the publicly funded and publicly administered health care system, it is vital to safeguard these principles.

As was evident and a concern to many of us at the recent Halifax meeting, a trend toward divergent interpretations of the Act is developing. While I will deal with other issues at the end of this letter, my primary concern is with private clinics and facility fees. The issue of private clinics is not new to us as Ministers of Health; it formed an important part of our discussions in Halifax last year. For reasons I will set out below, I am convinced that the growth of a second tier of health care facilities providing medically necessary services that operate, totally or in large part, outside the publicly funded and publicly administered system, presents a serious threat to Canada's health care system.

Specifically, and most immediately, I believe the facility fees charged by private clinics for medically necessary services are a major problem which must be dealt with firmly. It is my position that such fees constitute user charges and, as such, contravene the principle of accessibility set out in the *Canada Health Act*.

While there is no definition of facility fees in federal or most provincial legislation, the term, generally speaking, refers to amounts charged for non-physician (or "hospital") services provided at clinics and not reimbursed by the province. Where these fees are charged for medically necessary services in clinics which receive funding for these services under a provincial health insurance plan, they constitute a financial barrier to access. As a result, they violate the user charge provision of the Act (section 19).

Facility fees are objectionable because they impede access to medically necessary services. Moreover, when clinics which receive public funds for medically necessary services also charge facility fees, people who can afford the fees are being directly subsidized by all other Canadians. This subsidization of two-tier health care is unacceptable.

The formal basis for my position on facility fees is twofold. The first is a matter of policy. In the context of contemporary health care delivery, an interpretation which permits facility fees for medically necessary services so long as the provincial health insurance plan covers physician fees runs counter to the spirit and intent of the Act. While the appropriate provision of many physician services at one time required an overnight stay in a hospital, advances in medical technology and the trend toward providing medical services in more accessible settings has made it possible to offer a wide range of medical procedures on an out-patient basis or outside of full-service hospitals. The accessibility criterion in the Act, of which the user charge provision is just a specific example, was clearly intended to ensure that Canadian residents receive all medically necessary care without financial or other barriers and regardless of venue. It must continue to mean that as the nature of medical practice evolves.

Second, as a matter of legal interpretation, the definition of "hospital" set out in the Act includes any facility which provides acute, rehabilitative or chronic care. This definition covers those health care facilities known as "clinics". As a matter of both policy and legal interpretation, therefore, where a provincial plan pays the physician fee for a medically necessary service delivered at a clinic, it must also pay for the related hospital services provided or face deductions for user charges.

I recognize that this interpretation will necessitate some changes in provinces where clinics currently charge facility fees for medically necessary services. As I do not wish to cause undue hardship to those provinces, I will commence enforcement of this interpretation as of October 15, 1995. This will allow the provinces the time to put into place the necessary legislative or regulatory framework. As of October 15, 1995, I will proceed to deduct from transfer payments any amounts charged for facility fees in respect of medically necessary services, as mandated by section 20 of the *Canada Health Act*. I believe this provides a reasonable transition period, given that all provinces have been aware of my concerns with respect to private clinics for some time, and given the promising headway already made by the Federal/Provincial/Territorial Advisory Committee on Health Services, which has been working for some time now on the issue of private clinics.

I want to make it clear that my intent is not to preclude the use of clinics to provide medically necessary services. I realize that in many situations they are a cost-effective way to deliver services, often in a technologically advanced manner. However, it is my intention to ensure that medically necessary services are provided on uniform terms and conditions, wherever they are offered. The principles of the *Canada Health Act* are supple enough to accommodate the evolution of medical science and of health care delivery. This evolution must not lead, however, to a two-tier system of health care.

I indicated earlier in this letter that, while user charges for medically necessary services are my most immediate concern, I am also concerned about the more general issues raised by the proliferation of private clinics. In particular, I am concerned about their potential to restrict access by Canadian residents to medically necessary services by eroding our publicly funded system. These concerns were reflected in the policy statement which resulted from the Halifax meeting. Ministers of Health present, with the exception of the Alberta Minister, agreed to:

> take whatever steps are required to regulate the development of private clinics in Canada, and to maintain a high quality, publicly funded medicare system.

Private clinics raise several concerns for the federal government, concerns which provinces share. These relate to:

- weakened public support for the tax funded and publicly administered system;
- the diminished ability of governments to control costs once they have shifted from the public to the private sector;
- the possibility, supported by the experience of other jurisdictions, that private facilities will concentrate on easy procedures, leaving public facilities to handle more complicated, costly cases; and
- the ability of private facilities to offer financial incentives to health care providers that could draw them away from the public system - resources may also be devoted to features which attract consumers, without in any way contributing to the quality of care.

The only way to deal effectively with these concerns is to regulate the operation of private clinics.

I now call on Ministers in provinces which have not already done so to introduce regulatory frameworks to govern the operation of private clinics. I would emphasize that, while my immediate concern is the elimination of user charges, it is equally important that these regulatory frameworks be put in place to ensure reasonable access to medically necessary services and to support the viability of the publicly funded and administered system in the future. I do not feel the implementation of such frameworks should be long delayed.

I welcome any questions you may have with respect to my position on private clinics and facility fees. My officials are willing to meet with yours at any time to discuss these matters. I believe that our officials need to focus their attention, in the coming weeks, on the broader concerns about private clinics referred to above.

As I mentioned at the beginning of this letter, divergent interpretations of the *Canada Health Act* apply to a number of other practices. It is always my preference that matters of interpretation of the Act be resolved by finding a Federal/Provincial/Territorial consensus consistent with its fundamental principles. I have therefore encouraged F/P/T consultations in all cases where there are disagreements. In situations such as out-of-province or out-of-country coverage, I remain committed to following through on these consultative processes as long as they continue to promise a satisfactory conclusion in a reasonable time.

In closing, I would like to quote Mr. Justice Emmett M. Hall. In 1980, he reminded us:

> "we, as a society, are aware that the trauma of illness, the pain of surgery, the slow decline to death, are burdens enough for the human being to bear without the added burden of medical or hospital bills penalizing the patient at the moment of vulnerability."

I trust that, mindful of these words, we will continue to work together to ensure the survival, and renewal, of what is perhaps our finest social project.

As the issues addressed in this letter are of great concern to Canadians, I intend to make this letter publicly available once all provincial Health Ministers have received it.

Yours sincerely,

Diane Marleau
Minister of Health

Annex D - Dispute Avoidance and Resolution Process under the Canada Health Act

In 1999, under the Social Union Framework Agreement (SUFA), the federal and provincial/territorial governments committed to working collaboratively to avoid and resolve intergovernmental disputes, while also respecting the legislative provisions of the governments involved. The section of the framework related to dispute avoidance and resolution provided guidelines for the development of the process in the areas of intergovernmental initiatives, including the interpretation of the *Canada Health Act* principles.

Work on the development of a *Canada Health Act* dispute avoidance and resolution process was initiated at the 2000 Conference of Ministers of Health on the basis that it would be consistent with SUFA commitments and the federal government's obligations under the *Canada Health Act*.

On April 2, 2002, the Honourable A. Anne McLellan, federal Minister of Health, wrote to the Honourable Gary Mar, Alberta Minister of Health and Wellness, outlining a dispute avoidance and resolution process as it would apply to the interpretation of the principles of the *Canada Health Act*. In response, Premier Klein accepted the process as outlined in Minister McLellan's letter on behalf of all provincial and territorial governments with the exception of the Quebec government.

On the following pages you will find the full text of Minister McLellan's letter to the Honourable Gary Mar, as well as a fact sheet on the Canada Health Act Dispute Avoidance and Resolution process.

Minister of Health Ministre de la Santé

Ottawa, Canada K1A 0K9

April 2, 2002

The Honourable Gary Mar, M.L.A.
Minister of Health and Wellness
Province of Alberta
Room 323, Legislature Building
Edmonton, Alberta
T5K 2B6

Dear Mr. Mar:

I am writing in fulfilment of my commitment to move forward on dispute avoidance and resolution as it applies to the interpretation of the principles of the *Canada Health Act.*

I understand the importance provincial and territorial governments attach to having a third party provide advice and recommendations when differences occur regarding the interpretation of the *Canada Health Act.* This feature has been incorporated in the approach to the *Canada Health Act* Dispute Avoidance and Resolution process set out below. I believe this approach will enable us to avoid and resolve issues related to the interpretation of the principles of the *Canada Health Act* in a fair, transparent and timely manner.

Dispute Avoidance

The best way to resolve a dispute is to prevent it from occurring in the first place. The federal government has rarely resorted to penalties and only when all other efforts to resolve the issue have proven unsuccessful. Dispute avoidance has worked for us in the past and it can serve our shared interests in the future. Therefore, it is important that governments continue to participate actively in ad hoc federal/provincial/territorial committees on *Canada Health Act* issues and undertake government-to-government information exchange, discussions and clarification on issues as they arise.

Moreover, Health Canada commits to provide advance assessments to any province or territory upon request.

Dispute Resolution

Where the dispute avoidance activities between the federal government and a provincial or territorial government prove unsuccessful, either Minister of Health involved may initiate dispute resolution by writing to his or her counterpart. Such a letter would describe the issue in dispute. If initiated, dispute resolution will precede any action taken under the non-compliance provisions of the Act.

As a first step, governments involved in the dispute will, within 60 days of the date of the letter initiating the process, jointly:

- collect and share all relevant facts;
- prepare a fact-finding report;
- negotiate to resolve the issue in dispute; and
- prepare a report on how the issue was resolved.

If, however, there is no agreement on the facts, or if negotiations fail to resolve the issue, any Minister of Health involved in the dispute may initiate the process to refer the issue to a third party panel by writing to his or her counterpart. Within 30 days of the date of that letter, a panel will be struck. The panel will be composed of one provincial/territorial appointee and one federal appointee who, together, will select a chairperson. The panel will assess the issue in dispute in accordance with the provisions of the *Canada Health Act*, will undertake fact-finding and provide advice and recommendations. It will then report to the governments involved on the issue within 60 days of appointment.

The Minister of Health for Canada has the final authority to interpret and enforce the *Canada Health Act*. In deciding whether to invoke the non-compliance provisions of the Act, the Minister of Health for Canada will take the panel's report into consideration.

Public Reporting

Governments will report publicly on *Canada Health Act* dispute avoidance and resolution activities, including any panel report.

I believe that the Government of Canada has followed through on its September 2000 Health Agreement commitments by providing funding of $21.1 billion in the fiscal framework and by working collaboratively in other areas identified in the agreement. I expect that provincial and territorial premiers and health ministers will honour their commitment to the health system accountability framework agreed to by First Ministers in September 2000. The work of officials on performance indicators has been collaborative and effective to date. Canadians will expect us to report on the full range of indicators by the agreed deadline of September 2002. While I am aware that some jurisdictions may not be able to fully report on all indicators in this timeframe, public accountability is an essential component of our effort to renew Canada's health care system. As such, it is very important that all jurisdictions work to report on the full range of indicators in subsequent reports.

In addition, I hope that all provincial and territorial governments will participate in and complete the joint review process agreed to by all Premiers who signed the Social Union Framework Agreement.

The *Canada Health Act* Dispute Avoidance and Resolution process outlined in this letter is simple and straightforward. Should adjustments be necessary in the future, I commit to review the process with you and other Provincial/Territorial Ministers of Health. By using this approach, we will demonstrate to Canadians that we are committed to strengthening and preserving medicare by preventing and resolving *Canada Health Act* disputes in a fair and timely manner.

Yours sincerely,

A. Anne McLellan

Fact Sheet: Canada Health Act Dispute Avoidance and Resolution Process

Scope

The provisions described apply to the interpretation of the principles of the *Canada Health Act*.

Dispute Avoidance

To avoid and prevent disputes, governments will continue to:

- participate actively in ad hoc federal/provincial/territorial committees on *Canada Health Act* issues; and
- undertake government-to-government information exchange, discussions and clarification on issues as they arise.

Health Canada commits to provide advance assessments to any province or territory upon request.

Dispute Resolution

Where the dispute avoidance activities between the federal government and a provincial or territorial government prove unsuccessful, either Minister of Health involved may initiate dispute resolution by writing to his or her counterpart. Such a letter would describe the issue in dispute. If initiated, dispute resolution will precede any action taken under the non-compliance provisions of the Act.

As a first step, governments involved in the dispute will, within 60 days of the date of the letter initiating the process, jointly:

- collect and share all relevant facts;
- prepare a fact-finding report;
- negotiate to resolve the issue in dispute; and
- prepare a report on how the issue was resolved.

If however, there is no agreement on the facts, or if negotiations fail to resolve the issue, any Minister of Health involved in the dispute may initiate the process to refer the issue to a third party panel by writing to his or her counterpart.

- Within 30 days of the date of that letter, a panel will be struck. The panel will be composed of one provincial/territorial appointee and one federal appointee, who, together will select a chairperson.
- The panel will assess the issue in dispute in accordance with the provisions of the *Canada Health Act*, will undertake fact-finding and provide advice and recommendations.
- The panel will then report to the governments involved on the issue within 60 days of appointment.

The Minister of Health for Canada has the final authority to interpret and enforce the *Canada Health Act*. In deciding whether to invoke the non-compliance provisions of the Act, the Minister of Health for Canada will take the panel's report into consideration.

Public Reporting

Governments will report publicly on *Canada Health Act* dispute avoidance and resolution activities, including any panel report.

Review

Should adjustments be necessary in the future, the Minister of Health for Canada commits to review the process with Provincial and Territorial Ministers of Health.

Annex E - Deductions and Refunds Under the Canada Health Act

Annex E details the deductions and refunds made to provincial and territorial transfer payments since the passage of the *Canada Health Act* in 1984.

Table 1 presents annual deductions from transfer payments by province and territory, while Table 2 summarizes all deductions and refunds since the Act came into force.

- In 2001-2002 deductions of $39,000 were made to transfer payments under the Canada Health and Social Transfer for the Province of Nova Scotia with respect to user fees.
- During fiscal year 1999-2000, monthly deductions applied to Nova Scotia's transfer payments totalled $57,360. However, Nova Scotia recently reported that for fiscal year 1999-2000 actual user charges at the private clinic were $39,000. As a result, an additional positive adjustment of $18,360 (difference between $57,360 and $39,000) was made to the August 2002 CHST transfer. The adjusted amount of $39,000 for 1999-2000 is shown in Table 1.

Refunds of deductions made in fiscal year 1986-1987 were permitted under Section 20(5) of the *Canada Health Act*, which during the first three years of the Act allowed refunds where provinces were deemed to have eliminated extra-billing and user charges.

Table 1 – Annual Deductions by Province and Territory Since Passage of the Canada Health Act

(in thousands of dollars)

Province/Territory	1984-1985[1]		1985-1986[1]		1986-1987[1]		1987-1988 to 1991-1992	1992-1993		1993-1994		1994-1995	
	Extra-Billing	User Charges	Extra-Billing	User Charges	Extra-Billing	User Charges	Extra-Billing and User Charges	Extra-Billing	User Charges	Extra-Billing	User Charges	Extra-Billing	User Charges
Newfoundland and Labrador							There were no deductions during this period.						
Prince Edward Island													
Nova Scotia													
New Brunswick	63	3,015	84	3,222	206	296							
Quebec		7,893		6,139									
Ontario	39,996		55,328		13,332								
Manitoba	810		460										
Saskatchewan	1,451		656										
Alberta	8,109	1,827	9,216	2,640	5,878	1,362							
British Columbia		22,797		30,620		31,332		83		1,223		676	
Yukon													
Northwest Territories													
Nunavut[2]													
Total	50,429	35,532	65,744	42,621	19,416	32,990		83		1,223		676	

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[1] These monies were subsequently reimbursed pursuant to Section 20.(5) of the *Canada Health Act*, for extra-billing and user charges deductions made during the period 1984-1985 to 1986-1987.

[2] Nunavut was formed as a Territory on April 1, 1999. Prior to fiscal year 1999-2000, all federal transfers and deductions for the region would have been included with that of the Northwest Territories.

Table 1 – Annual Deductions by Province and Territory Since Passage of the Canada Health Act (continued)

(in thousands of dollars)

Province/Territory	1995-1996		1996-1997		1997-1998		1998-1999		1999-2000		2000-2001		2001-2002	
	Extra-billing	User Charges	Extra-billing	User Charges	Extra-billing	User Charges	Extra-billing	User Charges	Extra-billing	User Charges	Extra-billing	User Charges	Extra-billing	User Charges
Newfoundland and Labrador		46		96		128		53						
Prince Edward Island														
Nova Scotia		32		72		57		39		39		39		39
New Brunswick														
Quebec														
Ontario														
Manitoba		269		588		587		612						
Saskatchewan														
Alberta		2,319		1,266										
British Columbia	43													
Yukon														
Northwest Territories														
Nunavut[3]														
Provincial/Territorial Total	43	2,666		2,022		772		704		39		39		39

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[3] Nunavut was formed as a Territory on April 1, 1999. Prior to fiscal year 1999-2000, all federal transfers and deductions for the region would have been included with that of the Northwest Territories.

Table 2 – Summary of Deductions and Refunds by Province and Territory Since Passage of the Canada Health Act

(in thousands of dollars)

Province/Territory	Total Gross Deductions 1984-1985 to 2001-2002			Refunds[4] 1984-1985 to 1986-1987			Total Net Deductions 1984-1985 to 2001-2002		
	Extra-billing	User Charges	Total	Extra-billing	User Charges	Total	Extra-billing	User Charges	Total
Newfoundland and Labrador		323	323					323	323
Prince Edward Island									
Nova Scotia		317	317					317	317
New Brunswick	353	6,533	6,886	(353)	(6,533)	(6,886)			
Quebec		14,032	14,032		(14,032)	(14,032)			
Ontario	108,656		108,656	(108,656)		(108,656)			
Manitoba	1,270	2,056	3,326	(1,270)		(1,270)		2,056	2,056
Saskatchewan	2,107		2,107	(2,107)		(2,107)			
Alberta	23,203	9,414	32,617	(23,203)	(5,829)	(29,032)		3,585	3,585
British Columbia	2,025	84,749	86,774		(84,479)	(84,749)	2,025		2,025
Yukon									
Northwest Territories									
Nunavut[5]									
Provincial / Territorial Total	137,614	117,426	255,040	(135,589)	(111,143)	(246,732)	2,025	6,283	8,308

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[4] Refunds of deductions were permitted during the first three years of the *Canada Health Act* under Section 20(5), where provinces were deemed to have eliminated extra-billing and user charges.

[5] Nunavut was formed as a Territory on April 1, 1999. Prior to fiscal year 1999-2000, all federal transfers and deductions for the region would have been included with that of the Northwest Territories.

Annex F - Evolution of Federal Transfers and the Canada Health and Social Transfer

Since the federal government began contributing to provincial and territorial health insurance programs in 1958, the arrangements for these contributions have evolved. Prior to 1977, the federal government cost shared hospital and physician services with the provinces and territories. In 1977, cost sharing was replaced by block funding (Established Programs Financing - EPF). Then, on April 1, 1996, the Canada Health and Social Transfer (CHST) replaced the EPF and the Canada Assistance Plan (CAP) and continues to provide support through both cash and tax transfers for health and other social programs delivered by the provinces and territories. These arrangements are described in the following section. Further information of federal fiscal programs and arrangements are available from the Department of Finance.

Cost Sharing

Originally, the federal government's method of contributing to provincial and territorial hospital insurance programs was based on the cost to provinces and territories of providing insured hospital services. Under the *Hospital Insurance and Diagnostic Services Act* (1957), the federal government reimbursed the provinces and territories for approximately 50 percent of the costs of hospital insurance. Under the *Medical Care Act* (passed in 1966, came into effect in 1968), the federal contribution in support of medical care was 50 percent of the average national per capita costs of the insured services, multiplied by the number of insured persons in each province and territory.

Established Programs Financing (EPF)

In 1977, cost-sharing arrangements were replaced by Established Programs Financing. Unlike the previous cost-sharing arrangements, EPF was a block-funding system, no longer open-ended, although funding was from the start and for most of EPF history, tied to economic growth under various formulae.

Under EPF, cash and tax transfers were provided to the provinces and territories in support of health and post-secondary education. Except for the first few years, the EPF (cash plus tax transfers) was distributed among provinces and territories on an equal per capita basis.

Tax transfers were calculated based on the value of income tax points transferred by the federal government to the provinces and territories in 1977 (13.5 personal income tax points and one corporate income tax point).

EPF cash funds were transferred monthly to each province and territory, provided the provincial/territorial plan satisfied the criteria and conditions set out in the *Canada Health Act*.

In 1995-1996, the last year of EPF, provinces and territories received $22.0 billion total EPF entitlements (cash and tax), 71.2 percent of which was intended for health care and the rest for post-secondary education.

Canada Health and Social Transfer (CHST)

In the 1995 Budget, the federal government announced the Canada Health and Social Transfer, which replaced the EPF and the Canada Assistance Plan (CAP), the federal provincial cost-sharing plan for social services. When the CHST came into effect in 1996, provinces and territories received the same share of the CHST that they had received under the Canada Assistance Plan (CAP), and health and post-secondary education funding made under Established Programs Financing. The provincial and territorial distribution that existed under the previous programs was carried over into the CHST, but has been gradually adjusted to more closely reflect each province and territory's share of the Canadian population.

The CHST is a single block fund, consisting of both cash and tax transfers to the provincial and territorial governments in support of health, post-secondary education, and social services/ assistance programs.

For fiscal year 2001-2002, CHST payments amounted to $34.2 billion in the form of tax point transfers and cash contributions (Source: Finance Canada, October 2002, http://www.fin.gc.ca).

Making CHST Payments

The Department of Finance has been responsible for making CHST payments to the provinces and territories since April 1, 1996. However, the Minister of Health continues to be responsible for determining the amounts of any deductions or withholdings pursuant to the *Canada Health Act*, including those for extra-billing and user charges, and for communicating these amounts to the Department of Finance in advance of the payment dates. The Department of Finance then makes the actual deductions from the twice-monthly CHST payments to the provinces and territories.

Annex G – Glossary of Terms Used in the Annual Report

The terms described in this glossary are defined within the context of the *Canada Health Act*. In other situations, these terms may have different definition or interpretation.

Term	Explanation
Accessibility	The accessibility criterion of the *Canada Health Act* (section 12) requires that health insurance plans of provinces and territories provide: • insured health care services on uniform terms and conditions, on a basis that does not impede or preclude reasonable access to these services by insured persons, either directly or indirectly; • payment for insured health services according to a system of payment authorized by the law of the province or territory; • reasonable compensation to physicians and dentists for all the insured health care services they provide; and • payment to hospitals to cover the cost of insured health care services.
Acute Care	Acute care includes health services provided to persons suffering from serious and sudden health conditions that require ongoing professional nursing care and observation. Examples of acute care include post-operative observation in an intensive care unit, and care and observation while waiting for emergency surgery.
Acute Care Bed	An acute care bed is a bed in a health care facility that has been designated for the treatment or care of an in-patient with an acute disease or health condition.
Acute Care Facility	An acute care facility is a health care facility providing care or treatment of patients with an acute disease or health condition.
Admission	The official acceptance into a health care service facility and the assignment of a bed to an individual requiring medical or health services on a time-limited basis.
Approved Bed Complement	Number of beds that a health care facility has been approved to operate in order to meet health service delivery expectations. Approval is by the province, territory or the federal government in the case of a federal hospital.
Average In-patient Per Diem Cost	This is the estimated average amount that a province or territory establishes as the average daily cost of an in-patient treatment or a stay in a health care facility.
Block Fee	This is a fee charged by a physician for services that are uninsured by the provincial or territorial health insurance plan, such as telephone advice, renewal of prescriptions by telephone, and completion of forms or documents.
Canada Health Act (CHA)	The *Canada Health Act* received Royal Assent on April 17, 1984, with the unanimous support of the House of Commons and the Senate. The Act, which replaced the *Hospital Insurance and Diagnostic Services Act* (1957) and the *Medical Care Act* (1968), sets out the national standards that the provincial and territorial health insurance plans must meet in order to receive the full federal cash contribution under the Canada Health and Social Transfer.

Term	Explanation
Canada Health and Social Transfer (CHST)	The Canada Health and Social Transfer (CHST) is the largest federal transfer to provinces and territories, providing them with cash payments and tax transfers in support of health care, post-secondary education, social assistance and social services. The tax transfer component of the CHST occurred in 1977 when the federal government agreed with provincial and territorial governments to reduce its personal and corporate income tax rates, thus allowing them to raise their tax rates by the same amount. As a result, revenue that would have flowed to the federal government began to flow directly to provincial and territorial governments. The CHST gives provinces and territories the flexibility to allocate payments among social programs according to their priorities, while upholding the principles of the *Canada Health Act* and the condition that there be no period of minimum residency with respect to social assistance. The CHST came into effect on April 1, 1996, replacing the Canada Assistance Plan (CAP), which cost-shared provincial and territorial social assistance and social service programs, and Established Programs Financing (EPF), which provided funding to support health care and post-secondary education.
Chronic Care	Chronic care is care required by a person who is chronically ill or has a functional disability (physical or mental) whose acute phase of illness is over, whose vital processes may or may not be stable and who requires a range of services and medical management that can only be provided by a hospital.
Chronic Care Bed	A chronic care bed is a bed designated for ongoing in-patient, long-term medical services.
Chronic Care Facility	A chronic care facility is a facility providing ongoing, long-term, in-patient medical services. Chronic care facilities do not include nursing homes.
Comprehensiveness	A criterion of the *Canada Health Act* (section 9), which states that the health insurance plans of the provinces and territories must insure all insured health services (hospital, physician, surgical-dental) and, where provided by law in a province or territory, services rendered by other health care practitioners.
Consultation Process	Under Section 14(2) of the *Canada Health Act*, the Minister of Health must consult with a province or territory with respect to a potential breach of the five criteria and two conditions of the Act, before discretionary penalties can be levied for that province or territory.
Convention Refugee	A Convention Refugee is a person who has been found to fear persecution in his or her country of origin because of race, religion, nationality, membership in a social group or political opinion. In Canada, the Immigration and Refugee Board, Convention Refugee Determination Division, decides who is a Convention Refugee.
Coordinating Committee on Reciprocal Billing (CCRB)	The Coordinating Committee on Reciprocal Billing (CCRB), comprised of federal, provincial and territorial government health officials, was formed in 1991 to identify and resolve administrative issues related to interprovincial/territorial billing arrangements for medical (physician) and hospital services. The general intent of the provincial/territorial reciprocal billing agreements is to ensure that eligible Canadians have access to medically necessary health services when referred for these services outside their province or territory when travelling or during educational leave or temporary employment.

Term	Explanation
Day Surgery Bed	A day surgery bed is a bed in a health care facility designated for short-term (less than 24 hours) surgical services.
Diagnostic Physician Service	A diagnostic physician service is any medically required service rendered by a medical practitioner that detects or determines the presence of diseases or conditions.
Discretionary Penalties	Discretionary penalties are outlined in sections 14 to 17 of the *Canada Health Act*. Under these provisions, the federal minister of health may authorize that a reduction in federal payments to a province or territory under the Canada Health and Social Transfer be made when a breach any of the five criteria or two conditions of the *Canada Health Act* have been identified and could not otherwise be resolved through consultations between the respective levels of government. The amount of any deduction is based on the gravity of the default.
Dispute Avoidance and Resolution (DAR)	In April 2002, provincial and territorial governments accepted a CHA dispute avoidance and resolution (DAR) process that would apply to the interpretation of the principles of the CHA as outlined by the Honourable A. Anne McLellan, federal Minister of Health in a letter to the Honourable Gary Mar, Alberta Minister of Health and Wellness. The CHA dispute avoidance and resolution process commits governments to continue to actively participate in ad-hoc federal, provincial and territorial committees on CHA issues and undertake government-to-government information exchange, discussions and clarification on issues as they arise. Health Canada will also continue to provide advance assessments on provincial measures and direction, when requested. Please see Annex D for a more detailed description of the DAR process.
Eligibility and Portability Agreement (EPA)	The original Interprovincial/Territorial Agreement on Eligibility and Portability was approved by provincial and territorial Ministers of Health in 1971 and was implemented in 1972. The Agreement sets minimum standards with respect to interprovincial and territorial eligibility and portability of health insurance programs. Provinces and territories voluntarily apply the provisions of this agreement, thereby facilitating the mobility of Canadians and their access to health services throughout Canada. Officials meet periodically to review and revise the Agreement.
Enhanced Medical Goods and Services	These are medical goods or services provided in conjunction with insured services. They are usually a higher-grade service or product that is not medically necessary and provided to a patient for personal choice and convenience.
Epp Letter	In June 1985, approximately one year following the passage of the *Canada Health Act* in Parliament, then-federal Health Minister Jake Epp wrote to his provincial and territorial counterparts to set out and confirm the federal position on the interpretation and implementation of the *Canada Health Act*. Minister Epp's letter followed several months of consultation with his provincial and territorial counterparts. The letter sets forth statements of federal policy intent which clarify the criteria, conditions and regulatory provisions of the CHA. These clarifications have been used by the federal government in the assessment and interpretation of compliance with the Act. The Epp Letter (see Annex C) remains an important reference for interpretation of the Act.

Term	Explanation
Established Programs Financing (EPF)	Introduced in 1977, the *Federal-Provincial Fiscal Arrangements and Established Programs Financing Act*, also known as the *EPF Act*, replaced previous federal cost-sharing programs for insured hospital, medical and post-secondary transfers to provinces and territories. The EPF was a block-funding system that was tied to economic and population growth. Under the EPF, cash and tax transfers were provided to the provinces and territories in support of health and post-secondary education. In 1996, the EPF was replaced by the Canada Health and Social Transfer.
Extended Health Care Services	Section 2 of the *Canada Health Act* defines extended health care services as nursing home intermediate care service; adult residential care service; home care service; and ambulatory health care service.
Extra-billing	The *Canada Health Act* (section 2) defines extra-billing as billing for an insured health service rendered to an insured person by a medical practitioner or a dentist in an amount in addition to any amount paid or to be paid for that service by the health insurance plan of a province or territory.
Extra-billing and User Charges Information Regulations	The only regulations in force under the *Canada Health Act* are the Extra-billing and User Charges Information Regulations, which require the provinces and territories to provide estimates of extra-billing and user charges prior to the beginning of a fiscal year so that appropriate penalties can be levied, as well as financial statements showing the amounts actually charged so that reconciliations with the actual deductions can be made. (A copy of these regulations is provided in Annex B).
Federal Policy on Private Clinics (Marleau Letter)	On January 6, 1995, federal Minister of Health Diane Marleau wrote to all provinces and territories, providing them with the federal policy position and legal interpretation that the definition of "hospital" as set out in the *Canada Health Act* includes any facility providing acute, rehabilitative or chronic care and includes those health care facilities known as "clinics." She informed them that after October 15, 1995, it was her intention to interpret facility fees charged to patients in such facilities or clinics as user fees. Any province or territory not in compliance with the federal policy on private clinics faced mandatory penalties under the *Canada Health Act* calculated from October 15, 1995. These penalties take the form of deductions from monthly cash transfer payments under the Canada Health and Social Transfer. The Marleau Letter is included in Annex C of this annual report.
Fee-for-service	This is a method of payment for physicians based on a fee schedule that itemizes each service and provides a fee for each service rendered.
General Practitioner	This is a licensed physician in a province or territory who practises community-based medicine and refers patients to specialists when the diagnosis suggests it is appropriate. Some services a general practitioner may provide are: consultation, diagnosis, reference, counselling, advice on health care and prevention of illness, minor surgeries, and prescribing medicines.
Health Care Facility	A health care facility is a building or group of buildings under a common corporate structure that houses health care personnel and health care equipment to provide health care services (e.g., diagnostic, surgical, acute care, chronic care, dental care, physiotherapy) to the public in general or to a designated group of persons or residents.

Term	Explanation
Health Care Insurance Plan	The *Canada Health Act* (section 2) defines a health care insurance plan as a plan or plans established by the law of the province or territory to provide for insured health services.
Health Insurance Supplementary Fund (HISF)	This is a fund, administered by the Canada Health Act Division to assist eligible individuals who, through no fault of their own, have lost or been unable to obtain provincial or territorial coverage for insured health services under the *Canada Health Act*. The fund was first established in 1972, when the portability of insurance between provinces varied and allowed for discrepancies in eligibility rules whereby a resident of Canada could become temporarily ineligible for health insurance in a province or territory following a change of province or a change of health care eligibility status (e.g., discharge from RCMP or Canadian Forces). The passage of the *Canada Health Act* in 1984 eliminated the discrepancies in interprovincial eligibility periods that were the source of most concerns for which the fund was established. There is currently $28,387 in the fund. There have been 5 applications for claims to the HISF since 1986; however, none of these have qualified under the terms and conditions for reimbursement.
Hospital	A hospital is a health care facility located in Canada that provides medical or surgical treatment for the sick or injured, including acute, rehabilitative or chronic care, but does not include an institution primarily for the mentally disordered, nor does it include a facility or portion thereof that provides nursing home care, adult residential care, or comparable services for children.
Hospital Reciprocal Billing Agreement	This is a bilateral agreement between provinces or territories that allows for the reciprocal processing of out-of-province or territory claims for hospital in- and out-patient services. Under such an agreement, insured hospital services are payable at the approved rates of the host province or territory or as otherwise agreed upon by the parties involved or the Coordinating Committee on Reciprocal Billing (CCRB).
In-patient	This is a patient who is admitted to a hospital, clinic or other health care facility for treatment that requires at least one overnight stay.
Insured Health Services	The *Canada Health Act* defines insured health services (section 2) as hospital services, physician services and surgical-dental services provided to insured persons, but does not include any health services that a person is entitled to and eligible for under any other Act of Parliament or under any Act of the legislature of a province that relates to workers' compensation.
Insured Hospital Services	Insured hospital services are interpreted from the *Canada Health Act* as any of the following services provided to in- or out-patients at a hospital or health care facility, if the services are medically necessary, for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability. These are: • accommodation and meals at the standard or public ward level and preferred accommodation if medically required; • nursing service; • laboratory, radiological and other diagnostic procedures, together with the necessary interpretations; • drugs, biologicals and related preparations when administered in the hospital; • use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies; • medical and surgical equipment and supplies;

Term	Explanation
	• use of radiotherapy facilities; • use of physiotherapy facilities; and • services provided by persons who receive remuneration from the hospital or health care facility.
Insured Person	An insured person is interpreted under the *Canada Health Act* as a resident of a province or territory other than: • a member of the Canadian Forces, • a member of the Royal Canadian Mounted Police who is appointed to rank therein, • a person serving a term of imprisonment in a penitentiary as defined in the *Penitentiary Act*, or • a resident of the province or territory who has not completed such minimum period of residence or waiting period, not exceeding three months, as may be required by the province or territory for eligibility for or entitlement to insured health services.
Insured Physician Service	This is a medically required service covered by a provincial or territorial health insurance plan and administered by a medical practitioner.
Insured Surgical-Dental Service	Section 2 of the *Canada Health Act* defines surgical-dental services as any medically or dentally required surgical-dental procedures performed by a dentist in a hospital, where a hospital is required for the proper performance of the procedures.
Length of Stay	This is the number of days a patient is admitted to a health care facility.
Mandatory Penalties	Provinces that allow extra-billing and user charges are subject to mandatory dollar-for-dollar deductions from federal transfer payments. Mandatory penalties are outlined in sections 20 and 21 of the *Canada Health Act*. Under these provisions, the federal minister of health may authorize that a reduction in federal payments to a province or territory under the Canada Health and Social Transfer be made when a breach any of the extra-billing and user charges provisions of the *Canada Health Act* has been identified and could not otherwise be resolved through consultations between the respective levels of government.
Medical Practitioner	A medical practitioner is defined under section 2 of the *Canada Health Act* as a person lawfully entitled to practise medicine in the place in which the practice is carried on by that person.
Medical Reciprocal Billing Agreement	This is a bilateral agreement between provinces and territories that allows the reciprocal processing of out-of-province/territory claims for medical services provided by a licensed physician. Where an agreement exists, an insured medical service is payable at the approved rate of the host province or territory.
Non-participating Physician	This is a physician operating completely outside provincial or territorial health insurance plans. Neither the physician nor the patient is eligible for any cost coverage for services rendered or received from the provincial or territorial health insurance plans. A non-participating physician may therefore establish his or her own fees, which are paid directly by the patient.

Term	Explanation
Opted-out Physicians	These are physicians who operate outside the provincial or territorial health insurance plans, and who bill their patients directly at the provincial or territorial rate. The provincial or territorial plans reimburse these patients for charges up to, but not more than the amount paid by the plan for that service under fee schedule agreements.
Out-patient	This is a patient admitted to a hospital, clinic or other health care facility for treatment that does not require an overnight stay.
Out-patient Diagnostic Care	Out-patient diagnostic care includes health care services in a health care facility for procedures that do not require an overnight stay and that detect or determine various diseases or health conditions.
Out-patient Surgical Facility	This is a health care facility providing short-term (day only) surgical services.
Participating Physician/Dentist	These are licensed physicians or dentists who are enrolled in provincial or territorial health insurance plans.
Physician Services	For purposes of the *Canada Health Act*, physician services means any medically required services rendered by medical practitioners.
Portability	This criterion of the *Canada Health Act* (section 11) requires that provincial and territorial health insurance plans not impose any minimum period of residence, or waiting period in excess of three months before residents become eligible for insured health services. In addition, the plans must cover and pay for insured services provided to insured persons while they are temporarily outside the province and during any period of residence, or waiting period imposed by the health care insurance plan of another province or territory.
Private Diagnostic Facility	This is a privately owned health care facility providing laboratory tests, radiological services and other diagnostic procedures.
Private (for-profit) Health Care Facility	This is a privately owned health care facility that pays out dividends and/or profits to its owners, shareholders, operators or members.
Private (not-for-profit) Health Care Facility	This is a privately owned health care facility that is recognized as operating on a non-profit basis under the laws of the provincial, territorial or federal governments.
Private Surgical Facility	This is a privately owned health care facility providing surgical health services.
Provision of Information Condition	The *Canada Health Act* (section 13 (a)) requires that provincial and territorial governments provide information to the federal minister of health as may be reasonably required, in relation to insured health care services and extended health care services, for the purposes of administering the Act.
Public Administration Criterion	This criterion of the *Canada Health Act* (section 8) requires that provincial and territorial health care insurance plans be administered and operated on a non-profit basis, by public authorities that are responsible to the provincial or territorial governments, and that are subject to audits of their accounts and financial transactions.
Public Health Care Facility	A public health care facility is a publicly administered institution located within Canada that provides publicly insured health care services on an in- or out-patient basis.

Term	Explanation
Recognition Condition	The *Canada Health Act* (section 13(b)) requires that provincial and territorial governments give recognition to the Canada Health and Social Transfer in any public documents, advertisements or promotional material relating to insured health care services and extended health services in their province or territory.
Refugee Claimant	A refugee claimant is a person who has arrived in Canada and who requests refugee status. If a refugee claimant receives a final determination that he or she has been determined to be a Convention Refugee, he or she may then apply for permanent residence.
Rehabilitative Bed	This is a bed designated for in-patient, rehabilitative treatment services in a hospital setting (e.g., rehabilitative treatment for spinal or head injuries).
Rehabilitative Care	Rehabilitative care includes health care services for persons requiring professional assistance to restore physical skills and functionality following an illness or injury. An example is therapy required for a person recovering from a stroke (e.g., physiotherapy and speech therapy).
Resident	Under section 2 of the *Canada Health Act*, a resident is a person lawfully entitled to be or to remain in Canada who resides and is ordinarily present in the province or territory, but does not include a tourist, a transient or a visitor to the province or territory.
Separations	This is the total number of in- and out-patients released from a health facility following discharge, transfer, day surgery or death. Separations include newborns.
Specialist	A specialist is a licensed physician in a province or territory whose practice of medicine is primarily concerned with specialized diagnostic and treatment procedures. Specialties include, but are not limited to, anaesthesia, dermatology, general surgery, gynaecology, internal medicine, neurology, neuropathology, ophthalmology, paediatrics, plastic surgery, radiology and urology.
Staffed Beds	This is the number of beds for which a health care facility has staff to provide health services.
Surgical Day Care	Surgical day care includes health care services involving medical operative procedures delivered in a health care facility that do not require an overnight stay for post-operative recovery or observation.
Surgical-dental Services	The *Canada Health Act* defines surgical dental services as any medically or dentally required surgical-dental procedures performed by a dentist in a hospital, where a hospital is required for the proper performance of the procedure.
Surgical Physician Service	For purposes of reporting on the *Canada Health Act*, a surgical physician service is any medically required surgery rendered by a medical practitioner.
Temporarily Absent	This is where a person is absent from their province or territory of origin for business, education, vacation or other reasons, without assuming permanent residence elsewhere.
Third-party Payers	These are organizations such as workers' compensation boards, private health insurance companies and employer-based health care plans that pay for insured health services for their clients and employees.

Term	Explanation
Tray Fees	Tray fees are charges for items such as alcohol swabs, instruments and sutures that are associated with the provision of an insured physician service.
Universality	This criterion of the *Canada Health Act* (section 10) requires that provincial and territorial health care insurance plans entitle all insured persons in the province or territory to insured services on uniform terms and conditions.
User Charge	This is any charge for an insured health service that is authorized or permitted by a provincial or territorial health care insurance plan that is not payable, directly or indirectly, by a provincial or territorial health insurance plan, but does not include any charge imposed by extra-billing.

How to Contact Provincial and Territorial Departments of Health

Newfoundland and Labrador
Government Relations
Deaprtment of Health and Community Services
Confederation Building
P.O. Box 3700
St. John's, Newfoundland A1B 4J6
(709) 729-5303
www.gov.nf.ca/health/

Prince Edward Island
Director, Acute and Continuing Care
16 Garfield Street
P.O. Box 2000
Charlottetown, PEI C1A 7N8
(902) 368-6184
www.gov.pe.ca/hss/aacc-info/

Nova Scotia
Senior Policy Analyst, Intergovernmental Affairs
Nova Scotia Department of Health
1690 Hollis Street
Halifax, Nova Scotia B3J 2R8
(902) 424-5868
www.gov.ns.ca/health/

New Brunswick
Department of Health and Wellness
P.O. Box 5100
Fredericton, New Brunswick E3B 5G8
(506) 453-2536
www.gnb.ca/HW-SM/hw/

Quebec
Ministère de la Santé et des Services sociaux
1075, chemin Sainte-Foy, 2e étage
Québec (Québec) G1S 2M1
1-800-707-3380
www.msss.gouv.qc.ca/
www.ramq.gouv.qc.ca/eng/cit/

Ontario
Ministry of Health and Long-Term Care
Hepburn Block
10th Floor
80 Grosvenor Street
Toronto, Ontario M7A 2C4
1-800-268-1153
www.gov.on.ca/health/

Manitoba
Client Service Centre
Manitoba Health
300 Carlton Street
Winnipeg, Manitoba R3B 3M9
1-800-392-1207
www.gov.mb.ca/health

Saskatchewan
Saskatchewan Health
3475 Albert Street
Regina, Saskatchewan S4S 6X6
1-800-667-7766
www.health.gov.sk.ca/ps_benefits.html

Alberta
Alberta Health Care Insurance Plan
P.O. Box 1360
Edmonton, AB T5J 2N3
(780) 427-1432 (Edmonton)
www.health.gov.ab.ca/ahcip/

British Columbia
Ministry of Health Services
Ministry of Health Planning
PO Box 9050 Stn Prov Govt
Victoria, British Columbia V8W 9E2
1-800-661-4337
www.gov.bc.ca/healthservices
www.gov.bc.ca/healthplanning
hlth.health@gems1.gov.bc.ca

Yukon
Yukon Health Care Insurance
P.O. Box 2703
Whitehorse, Yukon Y1A 2C6
www.hss.gov.yk.ca/hsframe.html

Northwest Territories
Health Services Administration
Department of Health and Social Services
Government of NWT
Bag Service # 9 Inuvik, NT X0E 0T0
1-800-661-0830 or 1-867-777-7400
www.hlthss.gov.nt.ca/content/publications/publication_index.htm

Nunavut
Government of Nunavut
Department of Health and Social Services
P.O. Box 1000 Station 1000
Iqaluit, NU X0A 0H0
1-867-975-5700
www.gov.nu.ca/hss.htm